



Senate Bill No. 1240

Public Act No. 11-44

AN ACT CONCERNING THE BUREAU OF REHABILITATIVE SERVICES AND IMPLEMENTATION OF PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2011*) (a) There is created a Bureau of Rehabilitative Services, which shall be within the Department of Social Services for administrative purposes only. Said bureau shall be responsible for: (1) Providing services to the deaf and hearing impaired; (2) providing services for the blind and visually impaired; and (3) providing rehabilitation services in accordance with the provisions of the general statutes concerning said bureau.

(b) The department head shall be the director of the Bureau of Rehabilitative Services, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, of the general statutes, as amended by this act, and shall have the powers and duties described in said sections. The director shall appoint such persons as may be necessary to administer the provisions of this act and the Commissioner of Administrative Services shall fix the compensation of such persons in accordance with the provisions of section 4-40 of the general statutes. The director may create such

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sections within said bureau as will facilitate such administration, including a disability determinations section for which one hundred per cent federal funds may be accepted for the operation of such section in conformity with applicable state and federal regulations.

Sec. 2. (NEW) (*Effective July 1, 2011*) All functions, powers and duties of the Commission on the Deaf and Hearing Impaired under chapter 814a and sections 4-89, 9-20, 16-256b, 17a-248 and 51-245 of the general statutes, as amended by this act, are transferred to the Bureau of Rehabilitative Services, except as otherwise provided in sections 46a-27 and 46a-28 of the general statutes, as amended by this act. The Bureau of Rehabilitative Services shall constitute a successor to the Commission on the Deaf and Hearing Impaired, in accordance with the provisions of sections 4-38d and 4-38e of the general statutes, with respect to such functions, powers and duties.

Sec. 3. (NEW) (*Effective July 1, 2011*) All functions, powers and duties of the Board of Education and Services for the Blind under chapter 174 and sections 5-175a, 5-259, 10-76y, 12-217oo, 14-253a, 17a-248 and 17b-656 of the general statutes, as amended by this act, shall be transferred to the Bureau of Rehabilitative Services, except as provided in section 10-293 of the general statutes, as amended by this act. The Bureau of Rehabilitative Services shall constitute a successor to the Board of Education and Services for the Blind, in accordance with the provisions of sections 4-38d and 4-38e of the general statutes, with respect to such functions, powers and duties.

Sec. 4. (NEW) (*Effective July 1, 2011*) All functions, powers and duties of the Bureau of Rehabilitation Services of the Department of Social Services are transferred to the Bureau of Rehabilitative Services. The Bureau of Rehabilitative Services shall constitute a successor to the Bureau of Rehabilitation Services of the Department of Social Services, in accordance with the provisions of sections 4-38d and 4-38e of the general statutes.

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Sec. 5. Subsection (a) of section 5-175a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Vending stand operators, operating stands under permits held by the [State Board of Education and Services for the Blind] Bureau of Rehabilitative Services pursuant to section 10-303, as amended by this act, shall be members of the state employees retirement system, part A, exclusive of the Social Security option and benefits in the state employees' retirement system dependent thereon. Each such person shall annually, on or before June thirtieth, pay five per cent of his adjusted gross income, arising out of the operation of such stand, as determined under the Internal Revenue Code, during the calendar year preceding to the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services which shall, as the state administering agency for such persons, certify such payment and pay it over to the State Retirement Commission, provided membership of such persons in said system shall be exclusive of disability retirement upon the grounds of defects of vision.

Sec. 6. Subsection (a) of section 10-76y of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Notwithstanding any provision of the general statutes, school districts, regional educational service centers, the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services, and all other state and local governmental agencies concerned with education may loan, lease or transfer an assistive device for the use and benefit of a student with a disability to such student or the parent or guardian of such student or to any other public or private nonprofit agency providing services to or on behalf of individuals with disabilities including, but not limited to, an agency providing educational, health or rehabilitative services. Such device may be sold or transferred

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pursuant to this section regardless of whether the device was declared surplus. The sale or transfer shall be recorded in an agreement between the parties and based upon the depreciated value of the device. For the purposes of this section, "assistive device" means any item, piece of equipment or product system, whether acquired commercially off-the-shelf, modified or customized, that is used to increase, maintain or improve the functional capabilities of individuals with disabilities.

Sec. 7. Section 10-293 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) There is established a Board of Education and Services for the Blind that shall serve as [the central policy making authority in providing] an advisor to the Bureau of Rehabilitative Services in fulfilling its responsibilities in providing services to the blind and visually impaired in the state. [Prior to January 4, 2007, the Board of Education and Services for the Blind shall consist of seven members, six of whom shall be appointed by the Governor and shall be residents of this state. The Commissioner of Social Services shall be a member, ex officio. One of the members appointed by the Governor shall be the parent of a child who receives services provided by the board, and not less than two of the members appointed by the Governor shall be blind persons. One of the members appointed by the Governor shall be designated by the Governor as the chairperson of the board. The Governor may, for reasonable cause, remove any appointed member and appoint another person to fill the vacancy for the unexpired portion of the term. The board shall meet annually in the month of September and may meet at any other time upon the call of its chairperson; and the chairperson shall call a meeting at the request of two members. Any appointed member who fails to attend three consecutive meetings or fifty per cent of all meetings held during any calendar year shall be deemed to have resigned. A majority of the

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members in office shall constitute a quorum. The terms of the members of the board serving on June 2, 2006, shall expire on January 3, 2007.]

(b) (1) [On and after January 4, 2007, the] The Board of Education and Services for the Blind shall consist of members appointed as follows: Six appointed by the Governor, one appointed by the president pro tempore of the Senate, one appointed by the speaker of the House of Representatives, one appointed by the majority leader of the Senate, one appointed by the minority leader of the Senate, one appointed by the majority leader of the House of Representatives and one appointed by the minority leader of the House of Representatives and all shall be residents of the state. The Commissioner of Social Services shall be a member, ex officio. One of the members appointed by the Governor shall be the parent of a child who receives services provided by the board, and not less than two of the members appointed by the Governor shall be blind persons.

(2) Three members appointed by the Governor shall serve a term of four years. Three members appointed by the Governor shall serve a term of two years. The three members appointed by the president pro tempore of the Senate, the majority leader of the Senate and the minority leader of the Senate shall serve a term of four years. The three members appointed by the speaker of the House of Representatives, the majority leader of the House of Representatives, and the minority leader of the House of Representatives shall serve a term of two years. Thereafter, all members shall be appointed for a term of four years, commencing on January fourth of the year of the appointment.

(3) One of the members appointed by the Governor shall be designated by the Governor as the chairperson of the board. The board shall meet annually in the month of September and may meet at any other time upon the call of its chairperson; and the chairperson shall call a meeting at the request of two or more members. Any appointed member who fails to attend three consecutive meetings or fifty per cent

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of all meetings held during any calendar year shall be deemed to have resigned. A majority of the members in office shall constitute a quorum. The appointing authority may, for reasonable cause, remove any appointed member and appoint another person to fill the vacancy for the unexpired portion of the term. Any vacancy in the Board of Education and Services for the Blind shall be filled by the appointing authority for the unexpired portion of the term.

[(c) Members appointed to the Board of Education and Services for the Blind shall monitor the activities of the agency in carrying out its mission to provide educational and rehabilitative services to all state residents who are legally blind or visually impaired. Members shall also monitor the activities of the Board of Education and Services for the Blind regarding the agency's compliance with the benchmarks and recommendations set by the monitoring council established pursuant to section 3 of public act 03-217 and offer recommended adjustments to the benchmarks when deemed necessary. Not later than January 1, 2008, and annually thereafter, the members of the Board of Education and Services for the Blind shall report in accordance with section 11-4a, to the Governor, the Office of Policy and Management and to the joint standing committees of the General Assembly having cognizance of matters relating to human services and education on the agency's compliance with the benchmarks established by said monitoring council and on the activities of the agency in fulfilling its mission to provide educational and rehabilitative services to state residents who are legally blind or visually impaired.

(d) The Board of Education and Services for the Blind shall be within the Department of Social Services for administrative purposes only.]

Sec. 8. Section 10-295 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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(a) All residents of this state, regardless of age, who, because of blindness or impaired vision, require specialized vision-related educational programs, goods and services, on the signed recommendation of the director of the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services, shall be entitled to receive such instruction, programs, goods and services for such length of time as is deemed expedient by said director. Upon the petition of any parent or guardian of a blind child or a child with impaired vision, a local board of education may provide such instruction within the town or it may provide for such instruction by agreement with other towns as provided in subsection (d) of section 10-76d. All educational privileges prescribed in part V of chapter 164, not inconsistent with the provisions of this chapter, shall apply to the pupils covered by this subsection.

(b) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services shall expend funds for the services made available pursuant to subsection (a) of this section from the educational aid for blind and visually handicapped children account in accordance with the provisions of this subsection. The expense of such services shall be paid by the state in an amount not to exceed six thousand four hundred dollars in any one fiscal year for each child who is blind or visually impaired. The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services may adopt such regulations as [it] the director deems necessary to carry out the purpose and intent of this subsection.

(1) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services shall provide, upon written request from any interested school district, the services of teachers of the visually impaired, based on the levels established in the individualized education or service plan. The [agency] director of the Bureau of Rehabilitative Services shall also make available [its]

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resources, including, but not limited to, the Braille and large print library, to all teachers of public and nonpublic school children. The [agency] director may also provide vision-related professional development and training to all school districts and cover the actual cost for paraprofessionals from school districts to participate in agency-sponsored Braille training programs. The [agency] director shall utilize education consultant positions, [authorized as of July 1, 2001,] funded by moneys appropriated from the General Fund, to supplement new staffing that will be made available through the educational aid for the blind and visually handicapped children account, which shall be governed by formal written policies established by the [agency] director.

(2) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services shall use funds appropriated to said account, first to provide specialized books, materials, equipment, supplies, adaptive technology services and devices, specialist examinations and aids, preschool programs and vision-related independent living services, excluding primary educational placement, for eligible children without regard to a per child statutory maximum.

(3) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services may, within available appropriations, employ certified teachers of the visually impaired in sufficient numbers to meet the requests for services received from school districts. In responding to such requests, the [agency] director shall utilize a formula for determining the number of teachers needed to serve the school districts, crediting six points for each Braille-learning child and one point for each other child, with one full-time certified teacher of the visually impaired assigned for every twenty-five points credited. The [agency] director shall exercise due diligence to employ the needed number of certified teachers of the visually impaired, but shall not be liable for lack of resources. Funds

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appropriated to said account may also be utilized to employ rehabilitation teachers, rehabilitation technologists and orientation and mobility teachers in numbers sufficient to provide compensatory skills evaluations and training to blind and visually impaired children. In addition, up to five per cent of such appropriation may also be utilized to employ special assistants to the blind and other support staff necessary to ensure the efficient operation of service delivery. Not later than October first of each year, the [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services shall determine the number of teachers needed based on the formula provided in this subdivision. Based on such determination, the [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services shall estimate the funding needed to pay such teachers' salaries, benefits and related expenses.

(4) In any fiscal year, when funds appropriated to cover the combined costs associated with providing the services set forth in subdivisions (2) and (3) of this subsection are projected to be insufficient, the [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services shall be authorized to collect revenue from all school districts that have requested such services on a per student pro rata basis, in the sums necessary to cover the projected portion of these services for which there are insufficient appropriations.

(5) Remaining funds in said account, not expended to fund the services set forth in subdivisions (2) and (3) of this subsection, shall be used to cover on a pro rata basis, the actual cost with benefits of retaining a teacher of the visually impaired, directly hired or contracted by the school districts which opt to not seek such services from the [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services, provided such teacher has participated in not less than five hours of professional development

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training on vision impairment or blindness during the school year. Reimbursement shall occur at the completion of the school year, using the caseload formula denoted in subdivision (3) of this section, with twenty-five points allowed for the maximum reimbursable amount as established by the [agency] director annually.

(6) Remaining funds in such account, not expended to fund the services set forth in subdivisions (2), (3) and (5) of this subsection, shall be distributed to the school districts on a pro rata formula basis with a two-to-one credit ratio for Braille-learning students to non-Braille-learning students in the school district based upon the annual child count data provided pursuant to subdivision (1) of this subsection, provided the school district submits an annual progress report in a format prescribed by the [agency] director for each eligible child.

(c) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services may provide for the instruction of the adult blind in their homes, expending annually for this purpose such sums as the General Assembly may appropriate.

(d) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services may expend up to ten thousand dollars per fiscal year per person twenty-one years of age or over who is both blind or visually impaired and deaf for the purpose of providing services through specialized public and private entities from which such person can benefit. [Said board] The director may determine the criteria by which a person is eligible to receive specialized services and may adopt regulations necessary to carry out the provisions of this subsection.

(e) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services may, within available appropriations, purchase adaptive equipment for persons receiving services pursuant to this chapter.

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Sec. 9. Section 10-296 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The director of the Bureau of Rehabilitative Services may, within available appropriations, contract with public or private entities, individuals or private enterprises for the instruction of the blind.

Sec. 10. Section 10-297 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The director of the Bureau of Rehabilitative Services is authorized to aid in securing employment for capable blind or partially blind persons in industrial and mercantile establishments and in other positions which offer financial returns. Said director may aid needy blind persons in such way as said director deems expedient, expending for such purpose such sum as the General Assembly appropriates, provided the maximum expenditure for any one person shall not exceed the sum of nine hundred and sixty dollars in a fiscal year, but, if said maximum amount is insufficient to furnish necessary medical or hospital treatment to a beneficiary, said director may authorize payment of such additional costs as [he] the director deems necessary and reasonable.

Sec. 11. Section 10-297a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [executive director of the Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services may make grants, within available appropriations, to the Connecticut Radio Information Service, Inc., for the purchase of receivers and for costs related to the operation of said service.

Sec. 12. Section 10-298 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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(a) The [Board of Education and Services for the Blind] director of the Bureau of Rehabilitative Services shall, annually, as provided in section 4-60, submit to the Governor [its] a report, containing a statement of the activities of the [board] Bureau of Rehabilitative Services relating to services provided by the bureau to individuals in the state who are legally blind or visually impaired during the preceding year. [Said board] The director shall prepare and maintain a register of the blind in this state which shall describe their condition, cause of blindness and capacity for education and rehabilitative training. The [board] director may register cases of persons whose eyesight is seriously defective and who are liable to become visually disabled or blind, and may take such measures in cooperation with other authorities as [it] the director deems advisable for the prevention of blindness or conservation of eyesight and, in appropriate cases, for the education of children and for the vocational guidance of adults having seriously defective sight but who are not blind. The [agency] director shall establish criteria for low vision care and maintain a list of ophthalmologists and optometrists that are exclusively authorized to receive agency funds through established and existing state fee schedules for the delivery of specifically defined low vision services that increase the capacity of eligible recipients of such services to maximize the use of their remaining vision.

(b) The [board] director of the Bureau of Rehabilitative Services may accept and receive any bequest or gift of personal property and, subject to the consent of the Governor and Attorney General as provided in section 4b-22, any devise or gift of real property made to [said board] the Bureau of Rehabilitative Services, and may hold and use such property for the purposes, if any, specified in connection with such bequest, devise or gift.

(c) The [board] director of the Bureau of Rehabilitative Services shall provide the Department of Motor Vehicles with the names of all

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individuals sixteen years of age or older who, on or after October 1, 2005, have been determined to be blind by a physician or optometrist, as provided in section 10-305, as amended by this act. The [board] director of the Bureau of Rehabilitative Services shall provide simultaneous written notification to any individual whose name is being transmitted by the [board] director to [said department] the Department of Motor Vehicles. The [board] director of the Bureau of Rehabilitative Services shall update the list of names provided to the Department of Motor Vehicles on a quarterly basis. The list shall also contain the address and date of birth for each individual reported, as shown on the records of the [board] Bureau of Rehabilitative Services. The [department] Department of Motor Vehicles shall maintain such list on a confidential basis, in accordance with the provisions of section 14-46d. The [board] Bureau of Rehabilitative Services shall enter into a memorandum of understanding with the Department of Motor Vehicles to effectuate the purposes of this subsection.

Sec. 13. Section 10-298a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services may, within available appropriations, (1) maintain and develop workshops for training and employing blind persons in trades and occupations suited to their abilities, for the purpose of producing suitable products and services used by departments, agencies and institutions of the state and its political subdivisions, including, but not limited to towns, cities, boroughs and school districts; (2) aid blind persons in securing employment, in developing home industries and in marketing their products and services; (3) develop and implement rules and guidelines to guarantee that the dignity and rights of citizens involved in such workshops and work training programs shall be maintained; and (4) fund employment and vocational training at community rehabilitation facilities.

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(b) For any fiscal year that the [board] Bureau of Rehabilitative Services operates a workshop pursuant to subsection (a) of this section, the [board] director of the Bureau of Rehabilitative Services shall file with the Comptroller a balance sheet as of June thirtieth and a statement of operations for the fiscal year ending on that date. A copy of such statement shall be filed with the Auditors of Public Accounts.

Sec. 14. Section 10-298b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Whenever any of the products made or manufactured or services provided by blind persons under the direction or supervision of the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services meet the requirements of any department, institution or agency supported in whole or in part by the state as to quantity, quality and price such products shall have preference, except over articles produced or manufactured by Department of Correction industries as provided in section 18-88, and except for emergency purchases made under section 4-98. All departments, institutions and agencies supported in whole or in part by the state shall purchase such articles and services from the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services. Any political subdivision of the state may purchase such articles made or manufactured and services provided by the blind through the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services. [Said board] The bureau shall issue at sufficiently frequent intervals for distribution to the Commissioner of Administrative Services, the Comptroller and the political subdivisions of the state, a catalog showing styles, designs, sizes and varieties of all products made by blind persons pursuant to this section or disabled persons pursuant to section 17b-656, as amended by this act, and describing all available services provided by the blind or disabled.

Sec. 15. Section 10-298c of the general statutes is repealed and the

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following is substituted in lieu thereof (*Effective July 1, 2011*):

The Commissioner of Administrative Services shall (1) fix a fair market price, based on the cost of materials, labor and overhead, for all articles and services offered for sale and described in the most recent catalog issued by the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services pursuant to section 10-298b, as amended by this act, provided [that] the cost of labor on which such fair market price is based shall conform to federal minimum wage regulations for handicapped workers; (2) determine whether or not products produced or services provided by blind persons or handicapped persons meet the reasonable requirements of state departments, agencies and institutions; and (3) authorize state departments, agencies and institutions to purchase articles and services elsewhere when requisitions cannot be complied with through the products and services listed in the most current catalog issued by the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services pursuant to section 10-298b, as amended by this act.

Sec. 16. Section 10-300 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Any goods, wares or merchandise, manufactured or produced in whole or in part by the [board] Bureau of Rehabilitative Services or The Connecticut Institute for the Blind in furtherance of its purpose to instruct or employ the blind, may be sold or exchanged in any town, city or borough in this state and [said board] the bureau or institute, its agents or its employees shall not be required to procure a license therefor, and no law providing for the payment of a license fee for such privilege shall apply to [said board] the bureau or institute, its agents or employees, unless it or they are particularly referred to in its provisions.

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Sec. 17. Section 10-300a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) No goods, wares or merchandise shall be labeled, designated or represented as having been manufactured or produced in whole or in part by any blind person or by any public or private institute, agency or corporation serving the blind unless at least seventy-five per cent of the total hours of labor performed on such goods, wares or merchandise shall have been rendered by a blind person, as defined in section 10-294a. Any person, institute, agency or nonprofit corporation which so manufactures or produces such goods shall register annually, on July first, with the [board of education and services for the blind] Bureau of Rehabilitative Services and may affix or cause to be affixed to such goods a stamp or label which identifies such goods as the products of blind persons.

(b) The [Board of Education and Services for the Blind shall] Bureau of Rehabilitative Services may adopt regulations pursuant to the provisions of chapter 54 to carry out the provisions of this section.

(c) Any person, institute, agency or nonprofit corporation which violates any of the provisions of this section shall be fined not more than one hundred dollars for each violation.

Sec. 18. Section 10-303 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The authority in charge of any building or property owned, operated or leased by the state or any municipality therein shall grant to the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services a permit to operate in such building or on such property a food service facility, a vending machine or a stand for the vending of newspapers, periodicals, confections, tobacco products, food and such other articles as such authority approves when, in the

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opinion of such authority, such facility, machine or stand is desirable in such location. Any person operating such a stand in any such location on October 1, 1945, shall be permitted to continue such operation, but upon such person's ceasing such operation such authority shall grant a permit for continued operation to the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services. [Said board] The bureau may establish a training facility at any such location.

(b) Pursuant to the Randolph-Sheppard Vending Stand Act, 49 Stat. 1559 (1936), 20 USC 107, as amended from time to time, the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services is authorized to maintain a nonlapsing account and to accrue interest thereon for federal vending machine income which, in accordance with federal regulations, shall be used for the payment of fringe benefits to the vending facility operators by the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services.

(c) The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services may maintain a nonlapsing account and accrue interest thereon for state and local vending machine income which shall be used for the payment of fringe benefits, training and support to vending facilities operators, to provide entrepreneurial and independent-living training and equipment to children who are blind or visually impaired and adults who are blind and for other vocational rehabilitation programs and services for adults who are blind.

(d) The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services may disburse state and local vending machine income to student or client activity funds, as defined in section 4-52.

Sec. 19. Section 10-304 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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The sales and service account for the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services shall be established as a separate account within the General Fund for the purpose of aiding the blind by providing sales and service opportunities. Any money received by the [board] bureau from refunds for materials advanced for manufacture by the blind, and from the sales of articles or goods manufactured by the blind, and from the sale of other articles or goods, or from sales held to assist the blind, shall be deposited in the General Fund and credited to the account. Payments shall be made from the account for labor or services rendered in connection with the manufacture of articles for resale, for the purchase of materials used in such manufacture, for the purchase of merchandise for resale and for labor, supplies and other operating expenses connected with the operation of vending stands and sales and service opportunities. Bills contracted by the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services for the purposes specified in this section shall be paid by order of the Comptroller against the account in the manner provided by law for the payment of all claims against the state. At the end of each fiscal year, any surplus as of June thirtieth determined by including cash, accounts receivable and inventories less accounts payable over the sum of three hundred thousand dollars derived from sales of manufactured goods or articles or other sales, in excess of such cost of labor or services, materials, merchandise, supplies and other such operating expenses, shall revert to the General Fund of the state.

Sec. 20. Section 10-305 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Each physician and optometrist shall report in writing to the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services within thirty days each blind person coming under his or her private or institutional care within this state. The report of such blind

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person shall include the name, address, Social Security number, date of birth, date of diagnosis of blindness and degree of vision. Such reports shall not be open to public inspection.

Sec. 21. Section 10-306 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services may maintain a vocational rehabilitation program as authorized under the Federal Rehabilitation Act of 1973, 29 USC 791 et seq., for the purpose of providing and coordinating the full scope of necessary services to assist legally blind recipients of services from the [board] bureau to prepare for, enter into and maintain employment consistent with the purposes of said act.

Sec. 22. Section 10-307 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services is empowered to receive any federal funds made available to this state under which vocational rehabilitation is provided for a person whose visual acuity has been impaired and to expend such funds for the purpose or purposes for which they are made available. The State Treasurer shall be the custodian of such funds.

Sec. 23. Section 10-308 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services may cooperate, pursuant to agreements, with the federal government in carrying out the purposes of any federal statutes pertaining to vocational rehabilitation, and is authorized to adopt such methods of administration as are found by the federal government to be necessary for the proper and efficient operation of

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such agreements or plans for vocational rehabilitation and to comply with such conditions as may be necessary to secure the full benefits of such federal statutes.

Sec. 24. Section 10-308a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services shall adopt regulations, in accordance with chapter 54, to determine the order to be followed in selecting those eligible persons to whom vocational rehabilitation services will be provided, in accordance with federal regulations.

Sec. 25. Section 10-309 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Board of Education and Services for the Blind] Bureau of Rehabilitative Services may place in remunerative occupations persons whose capacity to earn a living has been lost or impaired by lessened visual acuity and who, in the opinion of the [board] director of the Bureau of Rehabilitative Services, are susceptible of placement, and may make such regulations as are necessary for the administration of the provisions of sections 10-306 to 10-310, inclusive, as amended by this act.

Sec. 26. Section 10-310 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The limitations on expenditures for a blind person provided in this chapter shall not apply to the expenditures for vocational rehabilitation of a person of lessened visual acuity as set forth in sections 10-306 to 10-309, inclusive, as amended by this act, provided the combined biennial expenditures under this chapter and under said sections shall not exceed the biennial appropriation to the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services

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by the General Assembly for the purpose of providing services to persons who are legally blind or visually impaired.

Sec. 27. Section 10-311a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The case records of the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services maintained for the purposes of this chapter shall be confidential and the names and addresses of recipients of assistance under this chapter shall not be published or used for purposes not directly connected with the administration of this chapter, except as necessary to carry out the provisions of sections 10-298, as amended by this act, and 17b-6.

Sec. 28. Subdivision (9) of section 17a-248 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(9) "Participating agencies" includes, but is not limited to, the Departments of Education, Social Services, Public Health, Children and Families and Developmental Services, the Insurance Department, the [Board of Education and Services for the Blind, the Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services and the Office of Protection and Advocacy for Persons with Disabilities.

Sec. 29. Section 17b-656 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Whenever any products made or manufactured by or services provided by persons with disabilities through community rehabilitation programs described in subsection (b) of section 17b-655, as amended by this act, or in any workshop established, operated or funded by nonprofit and nonsectarian organizations for the purpose of providing persons with disabilities training and employment suited to their abilities meet the requirements of any department, institution or

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agency supported in whole or in part by the state as to quantity, quality and price such products shall have preference over products or services from other providers, except (1) [articles produced or manufactured by blind persons under the direction or supervision of the Board of Education and Services for the Blind as provided in section 10-298a, (2)] articles produced or manufactured by Department of Correction industries as provided in section 18-88, [(3)] (2) emergency purchases made under section 4-98, and [(4)] (3) janitorial services provided by a qualified partnership, pursuant to the provisions of subsections (b) to (e), inclusive, of section 4a-82. All departments, institutions and agencies supported in whole or in part by the state shall purchase such articles made or manufactured and services provided by persons with disabilities from the [Bureau of Rehabilitation Services of the Department of Social Services] Bureau of Rehabilitative Services. Any political subdivision of the state may purchase such articles and services through the [Bureau of Rehabilitation Services of the Department of Social Services] Bureau of Rehabilitative Services. A list describing styles, designs, sizes and varieties of all such articles made by persons with disabilities and describing all available services provided by such persons shall be prepared by the Connecticut Community Providers Association. [The Bureau of Rehabilitation Services of the Department of Social Services shall cooperate with the State Board of Education and Services for the Blind by submitting necessary information concerning such products and services to the Board of Education and Services for the Blind at frequent intervals.]

Sec. 30. Section 26-29 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

No fee shall be charged for any sport fishing license issued under this chapter to any blind person, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. Proof

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of such blindness shall be furnished, in the case of a veteran, by the United States Veterans' Administration and, in the case of any other person, by the [State Board of Education of the Blind] Bureau of Rehabilitative Services. For the purpose of this section, a person shall be blind only if his central visual acuity does not exceed 20/200 in the better eye with correcting lenses, or if his visual acuity is greater than 20/200 but is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees.

Sec. 31. Section 4-5 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Management and Homeland Security, Commissioner of Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Liquor Control Commission, Commissioner of Mental Health and Addiction Services, Commissioner of Public Safety, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Public Works, Commissioner of Veterans' Affairs, Chief Information Officer, the chairperson of the Public Utilities Control Authority, [the executive director of the Board of Education and Services for the Blind] the director of the Bureau of Rehabilitative Services, the executive director of the Connecticut Commission on Culture and Tourism, and the executive director of the Office of Military Affairs. As used in sections

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4-6 and 4-7, "department head" also means the Commissioner of Education.

Sec. 32. Subsection (e) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(e) Notwithstanding the provisions of subsection (a) of this section, (1) vending stand operators eligible for membership in the state [employee's] employees' retirement system pursuant to section 5-175a, as amended by this act, shall be eligible for coverage under the group hospitalization and medical and surgical insurance plans procured under this section, provided the cost for such operators' insurance coverage shall be paid by the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services from vending machine income pursuant to section 10-303, as amended by this act, and (2) blind persons employed in workshops, established pursuant to section 10-298a, as amended by this act, on December 31, 2002, shall be eligible for coverage under the group hospitalization and medical and surgical insurance plans procured under this section, provided the cost for such persons' insurance coverage shall be paid by the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services. General workers employed in positions by the Department of Developmental Services as self-advocates, not to exceed eleven employees, shall be eligible for sick leave, in accordance with section 5-247, vacation and personal leave, in accordance with section 5-250, and holidays, in accordance with section 5-254.

Sec. 33. (NEW) (*Effective July 1, 2011*) The Bureau of Rehabilitative Services may provide necessary services to deaf and hearing impaired persons, including, but not limited to, nonreimbursable interpreter services and message relay services for persons using telecommunication devices for the deaf.

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Sec. 34. Subsection (g) of section 4-89 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(g) The provisions of this section shall not apply to appropriations to the [Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services in an amount not greater than the amount of reimbursements of prior year expenditures for the services of interpreters received by the [commission] bureau during the fiscal year pursuant to section 46a-33b, as amended by this act, and such appropriations shall not lapse until the end of the fiscal year succeeding the fiscal year of the appropriation.

Sec. 35. Section 46a-27 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

[A state commission] The Commission on the Deaf and Hearing Impaired is hereby created [as a state-wide coordinating agency] to advocate, strengthen and [implement] advise the Bureau of Rehabilitative Services concerning state policies affecting deaf and hearing impaired individuals and their relationship to the public, industry, health care and educational opportunity. [Said commission shall be within the Department of Social Services for administrative purposes only. The commission may provide necessary services to deaf and hearing impaired persons including, but not limited to, nonreimbursable interpreter services and message relay services for persons using telecommunications devices for the deaf.]

Sec. 36. Section 46a-28 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [commission] Commission on the Deaf and Hearing Impaired shall consist of twenty-one members, three of whom shall be ex officio. The ex-officio members shall consist of the following

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individuals: The consultant appointed by the State Board of Education in accordance with section 10-316a, the president of the Connecticut Council of Organizations Serving the Deaf and the superintendent of the American School for the Deaf. The following members shall be voting members: The Commissioners of Public Health, Social Services, Mental Health, Education, Developmental Services, and Children and Families and the Labor Commissioner or their designees and eleven members appointed by the Governor. Of the members appointed by the Governor one shall be a physician licensed to practice medicine in this state and specializing in otolaryngology; one a parent of a student in a predominantly oral education program, one a parent of a student at the American School for the Deaf and one a parent of a student in a public school hearing impaired program, and seven deaf persons, one of whom shall be a parent.

(b) The commission shall meet at least quarterly or more often at the call of the chairperson or a majority of the members. A majority of the voting members in office but not less than seven voting members shall constitute a quorum.

(c) Any appointed member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned. Vacancies occurring otherwise than by expiration of term in the membership of the commission shall be filled by the officer authorized to make the original appointments.

(d) The members of the commission shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.

[(e) There shall be established the position of executive director who shall be the chief executive officer of the commission. His qualifications and compensation shall be determined by the Commissioner of Administrative Services, subject to the approval of the Secretary of the

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Office of Policy and Management, pursuant to section 4-40. Said executive director shall function under the direction of the commission.

(f) Subject to the provisions of chapter 67, the commission is authorized to employ such clerical and other assistance as it requires to carry out the provisions of sections 46a-27 to 46a-32, inclusive.]

Sec. 37. Subsection (c) of section 9-20 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The application for admission as an elector shall include a statement that (1) specifies each eligibility requirement, (2) contains an attestation that the applicant meets each such requirement, and (3) requires the signature of the applicant under penalty of perjury. Each registrar of voters and town clerk shall maintain a copy of such statement in braille, large print and audio form. The [Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services shall produce a videotape presenting such statement in voice and sign language and provide the videotape to the Secretary of the State who shall make copies of the videotape and provide a copy to the registrars of voters of any municipality, upon request and at a cost equal to the cost of making the copy. If a person applies for admission as an elector in person to an admitting official, such admitting official shall, upon the request of the applicant, administer the elector's oath.

Sec. 38. Section 16-256b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Each telephone company and each certified telecommunications provider that makes equipment available to customers shall make special telecommunications equipment capable of serving the needs of deaf and hearing and speech impaired persons available for rental or

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purchase and be responsible for the maintenance and repair of any such equipment it leases or sells.

(b) (1) Each domestic telephone company having at least one hundred thousand customers shall pay into a Special Telecommunications Equipment Fund twenty thousand dollars, [not later than July 1, 1992.] The fund shall be administered by the [Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services. The Department of Public Utility Control shall include all payments made by a company into said fund as operating expenses of the company for purposes of rate-making under section 16-19.

(2) Except for the funding specified in subdivision (1) of this subsection, the [State Commission on the Deaf and Hearing Impaired] director of the Bureau of Rehabilitative Services may draw on funds obtained through agreements between the state and domestic telephone companies in accordance with a plan developed, after notice and hearing, by the [commission] director not later than January first, annually, and approved by the joint standing committee of the General Assembly having cognizance of matters relating to public utilities. The plan shall provide for the distribution of moneys from the funds to deaf and hearing and speech impaired persons for the purchase, upgrading, rental, maintenance and repair of special telecommunications equipment capable of serving the needs of such persons or to vendors providing such equipment or servicing. The plan may also provide for the distribution of moneys from the funds for the provision of message relay services for persons using telecommunication devices for the deaf, upon a determination by the [commission] director that such moneys are needed to ensure that such services are made available to such persons and that there are adequate moneys in the funds for special telecommunications equipment purposes. The plan shall provide that not more than ten per

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cent of the moneys annually paid into the fund shall be allocated to the [commission] Bureau of Rehabilitative Services to carry out its administrative responsibilities under this subdivision and not more than five per cent of the moneys annually paid by a telephone company into the fund shall be allocated to such corporation to carry out its responsibilities under subdivision (1) of this subsection. All moneys allocated to the [commission] Bureau of Rehabilitative Services in accordance with this section shall be paid to the State Treasurer for deposit in the General Fund.

(3) The [Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services shall, not later than March first, annually, submit a written financial report on the fund it administers under subdivision (2) of this section to the General Assembly and the Auditors of Public Accounts. Such report shall include a balance sheet and income and expense statement for the preceding calendar year, clearly setting forth the fund's income and expenses and all amounts spent for the direct purpose of the fund.

(c) (1) Each telephone company and each certified telecommunications provider shall, in consultation with the [Commission on the Deaf and Hearing Impaired] director of the Bureau of Rehabilitative Services, prepare and submit to the Department of Public Utility Control and the joint standing committee of the General Assembly having cognizance of matters relating to public utilities a plan which shall provide that, to the extent possible, (A) not less than eighty per cent of the coin and coinless telephones installed for public use by the telephone company or certified telecommunications provider shall be equipped [, not later than July 1, 1995,] with controls for the amplification of incoming transmissions, [and not less than eighty per cent of the coin and coinless telephones installed for public use by the telephone company or certified telecommunications provider after July 1, 1995, shall be equipped with

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such controls,] and (B) not less than fifty per cent of the coin and coinless telephones installed for semipublic use by the telephone company or certified telecommunications provider pursuant to tariffs shall be equipped [, not later than July 1, 1995,] with such controls. [and not less than fifty per cent of the coin and coinless telephones installed for semipublic use by the telephone company or certified telecommunications provider pursuant to tariffs after July 1, 1995, shall be equipped with such controls.]

(2) Not later than July first, annually, each such telephone company and each such certified telecommunications provider shall submit a report to [said commission, department and joint standing committee] the Department of Public Utility Control, the Bureau of Rehabilitative Services and the joint standing committee of the General Assembly having cognizance of matters relating to public utilities on the implementation of the plan prepared under subdivision (1) of this subsection, provided, if a telephone company or a certified telecommunications provider documents in any such report that it has fully complied with the provisions of subdivision (1) of this subsection, it shall not be required to submit additional annual reports.

(3) The cost of compliance with the provisions of this subsection shall be recoverable from ratepayers through the overall rate structure approved by the Department of Public Utility Control.

(d) Not less than eighty per cent of the coin and coinless telephones installed for public use on or after July 1, 1993, by any person, other than a telephone company or a certified telecommunications provider shall be equipped with such amplification controls at the time the telephones are installed.

Sec. 39. Section 46a-29 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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(a) The [commission] director of the Bureau of Rehabilitative Services may request and shall receive from any department, division, board, bureau, commission or agency of the state or of any political subdivision thereof such assistance and data as will enable [it] the Bureau of Rehabilitative Services to properly [to] carry out its activities under sections [46a-27 to 46a-32] 46a-30 to 46a-33b, inclusive, as amended by this act, and section 33 of this act, and to effectuate the purposes therein set forth.

[(b) The commission shall be provided with necessary office space in Hartford by the Commissioner of Public Works.]

[(c)] (b) The Commissioner of Education shall assign one vocational rehabilitation consultant to act as a liaison staff member of the commission.

Sec. 40. Section 46a-30 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [commission] director of the Bureau of Rehabilitative Services may receive moneys from any source, including gifts, grants, bequests and reimbursements which moneys may be expended for the purposes designated by the donor or to effectuate the provisions of sections [46a-27 to 46a-30, inclusive, and 46a-32] 46a-29 to 46a-33b, inclusive, as amended by this act, and section 33 of this act.

(b) The [commission] director of the Bureau of Rehabilitative Services is empowered to expend its appropriation and receipts to initiate and support the provisions of said sections by contract or other arrangement and to contract for and engage consultants.

Sec. 41. Section 46a-32 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [commission] director of the Bureau of Rehabilitative Services

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shall make an annual report to the Governor and General Assembly which shall include [its] recommendations for needed programs to effectuate the provisions of sections 46a-29 to 46a-33b, inclusive, as amended by this act, and section 33 of this act. When advisable, the [commission] director may make an interim report to the Governor and the General Assembly with [its] recommendations, in order to afford opportunity for immediate action to be taken thereon.

Sec. 42. Section 46a-33a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) For the purposes of this section:

(1) "Interpreting" means the translating or transliterating of English concepts to a language concept used by a person who is deaf or hard of hearing or means the translating of a deaf or hard of hearing person's language concept to English concepts. Language concepts include, but are not limited to, the use of American Sign Language, English-based sign language, cued speech, oral transliterating and information received tactually;

(2) "Legal setting" means any criminal or civil action involving a court of competent jurisdiction, any investigation conducted by a duly authorized law enforcement agency, employment related hearings and appointments requiring the presence of an attorney;

(3) "Medical setting" means medical related situations including mental health treatment, psychological evaluations, substance abuse treatment, crisis intervention and appointments or treatment requiring the presence of a doctor, nurse or other health care professional; and

(4) "Educational setting" means a school or other educational institution, including elementary, high school and post-graduation schools where interpretive services are provided to a student.

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(b) [Commencing October 1, 1998, and annually thereafter, all] All persons providing interpreting services shall register, annually, with the [Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services. Such registration shall be on a form prescribed or furnished by the [commission] director of the Bureau of Rehabilitative Services and shall include the registrant's name, address, phone number, place of employment as interpreter and interpreter certification or credentials. [Commencing July 1, 2001, and annually thereafter, the commission] The bureau shall issue identification cards for those who register in accordance with this section.

(c) No person shall provide interpreting services unless such person is registered with the [commission] Bureau of Rehabilitative Services according to the provisions of this section and (1) has passed the National Registry of Interpreters for the Deaf written generalist test or the National Association of the Deaf-National Registry of Interpreters for the Deaf certification knowledge examination, holds a level three certification provided by the National Association of the Deaf, documents the achievement of two continuing education units per year for a maximum of five years of [commission-approved] training approved by the director of the Bureau of Rehabilitative Services, and on or before the fifth anniversary of having passed the National Registry of Interpreters for the Deaf written generalist test or the National Association of the Deaf-National Registry of Interpreters for the Deaf certification knowledge examination, has passed the National Registry of Interpreters for the Deaf performance examination or the National Association of the Deaf-National Registry of Interpreters for the Deaf national interpreter certification examination, (2) has passed the National Registry of Interpreters for the Deaf written generalist test or the National Association of the Deaf-National Registry of Interpreters for the Deaf certification knowledge examination and is a graduate of an accredited interpreter training program and documents

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the achievement of two continuing education units per year for a maximum of five years of [commission-approved] training approved by the director, and on or before the fifth anniversary of having passed the National Registry of Interpreters for the Deaf written generalist test or the National Association of the Deaf-National Registry of Interpreters for the Deaf certification knowledge examination, has passed the National Registry of Interpreters for the Deaf performance examination or the National Association of the Deaf-National Registry of Interpreters for the Deaf national interpreter certification examination, (3) holds a level four or higher certification from the National Association of the Deaf, (4) holds certification by the National Registry of Interpreters for the Deaf, (5) for situations requiring an oral interpreter only, holds oral certification from the National Registry of Interpreters for the Deaf, (6) for situations requiring a cued speech transliterator only, holds certification from the National Training, Evaluation and Certification Unit and has passed the National Registry of Interpreters for the Deaf written generalist test, (7) holds a reverse skills certificate or is a certified deaf interpreter under the National Registry of Interpreters for the Deaf, or (8) holds a National Association of the Deaf-National Registry of Interpreters for the Deaf national interpreting certificate.

(d) No person shall provide interpreting services in a medical setting unless such person is registered with the [commission] Bureau of Rehabilitative Services according to the provisions of this section and (1) holds a comprehensive skills certificate from the National Registry of Interpreters for the Deaf, (2) holds a certificate of interpretation or a certificate of transliteration from the National Registry of Interpreters for the Deaf, (3) holds a level four or higher certification from the National Association of the Deaf, (4) holds a reverse skills certificate or is a certified deaf interpreter under the National Registry of Interpreters for the Deaf, (5) for situations requiring an oral interpreter only, holds oral certification from the

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National Registry of Interpreters for the Deaf, (6) for situations requiring a cued speech transliterator only, holds certification from the National Training, Evaluation and Certification Unit and has passed the National Registry of Interpreters for the Deaf written generalist test, or (7) holds a National Association of the Deaf-National Registry of Interpreters for the Deaf national interpreting certificate.

(e) No person shall provide interpreting services in a legal setting unless such person is registered with the [commission] Bureau of Rehabilitative Services according to the provisions of this section and (1) holds a comprehensive skills certificate from the National Registry of Interpreters for the Deaf, (2) holds a certificate of interpretation and a certificate of transliteration from the National Registry of Interpreters for the Deaf, (3) holds a level five certification from the National Association of the Deaf, (4) holds a reverse skills certificate or is a certified deaf interpreter under the National Registry of Interpreters for the Deaf, (5) for situations requiring an oral interpreter only, holds oral certification from the National Registry of Interpreters for the Deaf, (6) for situations requiring a cued speech transliterator only, holds certification from the National Training, Evaluation and Certification Unit and has passed the National Registry of Interpreters for the Deaf written generalist test, or (7) holds a National Association of the Deaf-National Registry of Interpreters for the Deaf national interpreting certificate.

(f) The requirements of this section shall apply to persons who receive compensation for the provision of interpreting services and include those who provide interpreting services as part of their job duties.

[(g) The provisions of subsection (c) of this section shall not apply to any person providing interpreting services in an educational setting until July 1, 2003.]

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Sec. 43. Section 46a-33b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Upon the request of any person or any public or private entity, the [Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services shall provide interpreting services to assist such person or entity to the extent such persons who provide interpreting services are available. Any person or entity receiving interpreting services through the [commission] bureau shall reimburse the [commission] bureau for such services at a rate set by the [commission] director of the Bureau of Rehabilitative Services. The [commission] director shall adopt regulations in accordance with the provisions of chapter 54 to establish the manner of rate setting.

Sec. 44. Subsection (d) of section 51-245 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(d) Notwithstanding the provisions of subsections (a) and (b) of this section, if any juror is deaf or hearing impaired, such juror shall have the assistance of a qualified interpreter who shall be present throughout the proceeding and when the jury assembles for deliberation. Such interpreter shall be provided by the [Commission on the Deaf and Hearing Impaired] Bureau of Rehabilitative Services at the request of the juror or the court. Such interpreter shall be subject to rules adopted pursuant to section 51-245a.

Sec. 45. Subsection (b) of section 14-253a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) The Commissioner of Motor Vehicles shall accept applications and renewal applications for special license plates and removable windshield placards from (1) any person who is blind, as defined in

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section 1-1f; (2) any person with disabilities; (3) any parent or guardian of any person who is blind or any person with disabilities, if such person is under eighteen years of age at the time of application; (4) any parent or guardian of any person who is blind or any person with disabilities, if such person is unable to request or complete an application; and (5) any organization which meets criteria established by the commissioner and which certifies to the commissioner's satisfaction that the vehicle for which a plate or placard is requested is primarily used to transport persons who are blind or persons with disabilities. [On and after January 1, 2010, no] No person shall be issued a placard in accordance with this section unless such person is the holder of a valid motor vehicle operator's license, or identification card issued in accordance with the provisions of section 1-1h. The commissioner is authorized to adopt regulations for the issuance of placards to persons who, by reason of hardship, do not hold or cannot obtain an operator's license or identification card. The commissioner shall maintain a record of each placard issued to any such person. Such applications and renewal applications shall be on a form prescribed by the commissioner. In the case of persons with disabilities, the application and renewal application shall include: (A) Certification by a licensed physician, a physician assistant, or an advanced practice registered nurse licensed in accordance with the provisions of chapter 378, that the applicant is disabled; (B) certification by a licensed physician, a physician assistant, an advanced practice registered nurse licensed in accordance with the provisions of chapter 378, or a member of the handicapped driver training unit established pursuant to section 14-11b, that the applicant meets the definition of a person with a disability which limits or impairs the ability to walk, as defined in 23 CFR Section 1235.2. In the case of persons who are blind, the application or renewal application shall include certification of legal blindness made by the [Board of Education and Services for the Blind] Bureau of Rehabilitative Services, an ophthalmologist or an optometrist. Any person who makes a certification required by this

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subsection shall sign the application or renewal application under penalty of false statement pursuant to section 53a-157b. The commissioner, in said commissioner's discretion, may accept the discharge papers of a disabled veteran, as defined in section 14-254, in lieu of such certification. The [commissioner] Commissioner of Motor Vehicles may require additional certification at the time of the original application or at any time thereafter. If a person who has been requested to submit additional certification fails to do so within thirty days of the request, or if such additional certification is deemed by the [commissioner] Commissioner of Motor Vehicles to be unfavorable to the applicant, the commissioner may refuse to issue or, if already issued, suspend or revoke such special license plate or placard. The commissioner shall not issue more than one placard per applicant. The fee for the issuance of a temporary removable windshield placard shall be five dollars. Any person whose application has been denied or whose special license plate or placard has been suspended or revoked shall be afforded an opportunity for a hearing in accordance with the provisions of chapter 54.

Sec. 46. Section 14-11b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) There shall be within the [Department of Motor Vehicles] Bureau of Rehabilitative Services a unit for the purpose of evaluating and training [handicapped] persons with disabilities in the operation of motor vehicles. There shall be assigned to such unit a [handicapped] driver consultant for persons with disabilities who shall be under the direction of the [commissioner] director and who shall be responsible for overseeing the [handicapped] driver training program for persons with disabilities. In addition to such consultant there shall be assigned to the [handicapped] driver training unit for persons with disabilities such staff as is necessary for the orderly administration of the [handicapped] driver training program for persons with disabilities.

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The [handicapped] driver consultant for persons with disabilities and such other personnel as are assigned to the [handicapped] driver training unit for persons with disabilities shall, while engaged in the evaluation, instruction or examination of a [handicapped] person with disabilities, have the authority and immunities with respect to such activities as are granted under the general statutes to motor vehicle inspectors.

(b) Any resident of this state who has a serious physical or mental [handicap] disability which does not render [him] the resident incapable of operating a motor vehicle and who must utilize special equipment in order to operate a motor vehicle and who cannot obtain instruction in the operation of a motor vehicle through any alternate program, including but not limited to, other state, federal or privately operated drivers' schools shall be eligible for instruction under the [Department of Motor Vehicles handicapped] Bureau of Rehabilitative Services driver training program for persons with disabilities.

Sec. 47. Section 31-283a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [Workers' Compensation Commission] Bureau of Rehabilitative Services shall provide rehabilitation programs for employees suffering compensable injuries within the provisions of this chapter, which injuries disabled them from performing their customary or most recent work. The [chairman] director of the Bureau of Rehabilitative Services shall establish rehabilitation programs which shall best suit the needs of injured employees and shall make the programs available in convenient locations throughout the state. After consultation with the Labor Commissioner, the [chairman] director may establish fees for the programs, so as to provide the most effective rehabilitation programs at a minimum rate. In order to carry out the provisions of this section, the [chairman of the Workers' Compensation Commission] director shall adopt regulations, in accordance with the

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provisions of chapter 54 and, subject to the provisions of chapter 67, provide for the employment of necessary assistants.

(b) The [chairman] director of the Bureau of Rehabilitative Services shall be authorized to (1) enter into agreements with other state or federal agencies to carry out the purposes of this section and expend money for that purpose, and (2) on behalf of the state of Connecticut, develop matching programs or activities to secure federal grants or funds for the purposes of this section and may pledge or use funds supplied from the administrative costs fund, as provided in section 31-345, to finance the state's share of the programs or activities.

Sec. 48. Subsection (a) of section 31-296 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) If an employer and an injured employee, or in case of fatal injury the employee's legal representative or dependent, at a date not earlier than the expiration of the waiting period, reach an agreement in regard to compensation, such agreement shall be submitted in writing to the commissioner by the employer with a statement of the time, place and nature of the injury upon which it is based; and, if such commissioner finds such agreement to conform to the provisions of this chapter in every regard, the commissioner shall so approve it. A copy of the agreement, with a statement of the commissioner's approval, shall be delivered to each of the parties and thereafter it shall be as binding upon both parties as an award by the commissioner. The commissioner's statement of approval shall also inform the employee or the employee's dependent, as the case may be, of any rights the individual may have to an annual cost-of-living adjustment or to participate in a rehabilitation program administered by the Bureau of Rehabilitative Services under the provisions of this chapter. The commissioner shall retain the original agreement, with the commissioner's approval thereof, in the commissioner's office and, if

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an application is made to the superior court for an execution, the commissioner shall, upon the request of said court, file in the court a certified copy of the agreement and statement of approval.

Sec. 49. Section 31-300 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

As soon as may be after the conclusion of any hearing, but no later than one hundred twenty days after such conclusion, the commissioner shall send to each party a written copy of the commissioner's findings and award. The commissioner shall, as part of the written award, inform the employee or the employee's dependent, as the case may be, of any rights the individual may have to an annual cost-of-living adjustment or to participate in a rehabilitation program administered by the Bureau of Rehabilitative Services under the provisions of this chapter. The commissioner shall retain the original findings and award in said commissioner's office. If no appeal from the decision is taken by either party within twenty days thereafter, such award shall be final and may be enforced in the same manner as a judgment of the Superior Court. The court may issue execution upon any uncontested or final award of a commissioner in the same manner as in cases of judgments rendered in the Superior Court; and, upon the filing of an application to the court for an execution, the commissioner in whose office the award is on file shall, upon the request of the clerk of said court, send to the clerk a certified copy of such findings and award. In cases where, through the fault or neglect of the employer or insurer, adjustments of compensation have been unduly delayed, or where through such fault or neglect, payments have been unduly delayed, the commissioner may include in the award interest at the rate prescribed in section 37-3a and a reasonable attorney's fee in the case of undue delay in adjustments of compensation and may include in the award in the case of undue delay in payments of compensation, interest at twelve per cent per annum and a reasonable attorney's fee.

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Payments not commenced within thirty-five days after the filing of a written notice of claim shall be presumed to be unduly delayed unless a notice to contest the claim is filed in accordance with section 31-297. In cases where there has been delay in either adjustment or payment, which delay has not been due to the fault or neglect of the employer or insurer, whether such delay was caused by appeals or otherwise, the commissioner may allow interest at such rate, not to exceed the rate prescribed in section 37-3a, as may be fair and reasonable, taking into account whatever advantage the employer or insurer, as the case may be, may have had from the use of the money, the burden of showing that the rate in such case should be less than the rate prescribed in section 37-3a to be upon the employer or insurer. In cases where the claimant prevails and the commissioner finds that the employer or insurer has unreasonably contested liability, the commissioner may allow to the claimant a reasonable attorney's fee. No employer or insurer shall discontinue or reduce payment on account of total or partial incapacity under any such award, if it is claimed by or on behalf of the injured person that such person's incapacity still continues, unless such employer or insurer notifies the commissioner and the employee of such proposed discontinuance or reduction in the manner prescribed in section 31-296 and the commissioner specifically approves such discontinuance or reduction in writing. The commissioner shall render the decision within fourteen days of receipt of such notice and shall forward to all parties to the claim a copy of the decision not later than seven days after the decision has been rendered. If the decision of the commissioner finds for the employer or insurer, the injured person shall return any wrongful payments received from the day designated by the commissioner as the effective date for the discontinuance or reduction of benefits. Any employee whose benefits for total incapacity are discontinued under the provisions of this section and who is entitled to receive benefits for partial incapacity as a result of an award, shall receive those benefits commencing the day following the designated effective date for the discontinuance of

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benefits for total incapacity. In any case where the commissioner finds that the employer or insurer has discontinued or reduced any such payment without having given such notice and without the commissioner having approved such discontinuance or reduction in writing, the commissioner shall allow the claimant a reasonable attorney's fee together with interest at the rate prescribed in section 37-3a on the discontinued or reduced payments.

Sec. 50. Subsection (a) of section 31-349b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Any employee who has suffered a compensable injury under the provisions of this chapter, and who is receiving benefits for such injury from the Second Injury Fund pursuant to the provisions of section 31-349, may file a written request with the commissioner in the district where the original claim was filed for a hearing to determine whether the employee's injury constitutes a permanent vocational disability. The hearing shall be held within sixty days of the date the request was filed. Upon the request of the commissioner and prior to the conclusion of such hearing, the director of the [Division of Workers' Rehabilitation within the Workers' Compensation Commission] Bureau of Rehabilitative Services shall, after receiving such information on the case which the commissioner deems necessary, submit written recommendations concerning the case to the commissioner for his consideration. The commissioner shall issue his decision, in writing, within ten days after the conclusion of the hearing. If the commissioner determines that the employee's injury is a permanent vocational disability, the employee shall be issued a certificate of disability by the commissioner. Such certificate shall be effective for a stated period of time of from one to five years, as determined by the commissioner. The decision of the commissioner may be appealed in accordance with the provisions of section 31-301.

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Sec. 51. Subsection (a) of section 4a-82 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) For the purposes of this section:

(1) "Person with a disability" means any individual with a disability, excluding blindness, as such term is applied by the Department of Mental Health and Addiction Services, the Department of Developmental Services, the [Bureau of Rehabilitation Services within the Department of Social Services] Bureau of Rehabilitative Services or the Veterans' Administration and who is certified by the [Bureau of Rehabilitation Services within the Department of Social Services] Bureau of Rehabilitative Services as qualified to participate in a qualified partnership, as described in subsections (f) to (m), inclusive, of this section;

(2) "Vocational rehabilitation service" means any goods and services necessary to render a person with a disability employable, in accordance with Title I of the Rehabilitation Act of 1973, 29 USC 701 et seq., as amended from time to time;

(3) "Community rehabilitation program" means any entity or individual that provides directly for or facilitates the provision of vocational rehabilitation services to, or provides services in connection with, the recruiting, hiring or managing of the employment of persons with disabilities based on an individualized plan and budget for each worker with a disability;

(4) "Commercial janitorial contractor" means any for-profit proprietorship, partnership, joint venture, corporation, limited liability company, trust, association or other privately owned entity that employs persons to perform janitorial work, and that enters into contracts to provide janitorial services;

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(5) "Janitorial work" means work performed in connection with the care or maintenance of buildings, including, but not limited to, work customarily performed by cleaners, porters, janitors and handypersons;

(6) "Janitorial contract" means a contract or subcontract to perform janitorial work for a department or agency of the state; and

(7) "Person with a disadvantage" means any individual who is determined by the Labor Department, or its designee, to be eligible for employment services in accordance with the Workforce Investment Act or whose verified individual gross annual income during the previous calendar year was not greater than two hundred per cent of the federal poverty level for a family of four.

(b) The Commissioner of Administrative Services shall establish a pilot program, for a term of seven years, to create and expand janitorial work job opportunities for persons with a disability and persons with a disadvantage. Such pilot program shall consist of four identified projects for janitorial work. The program shall create a minimum of sixty full-time jobs or sixty full-time equivalents at standard wages for persons with disabilities and persons with disadvantages and have a total market value for all janitorial contracts awarded under the program of at least three million dollars. In establishing such pilot program, the Commissioner of Administrative Services may consult with the Commissioner of Social Services, the director of the Bureau of Rehabilitative Services and the Labor Commissioner.

(c) Notwithstanding any other provision of the general statutes, under such pilot program, the Commissioner of Administrative Services shall award four janitorial contracts, one for each identified project, pursuant to the following procedures: (1) Upon receipt of a request for janitorial services by an agency or department of the state, the Commissioner of Administrative Services shall notify each

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qualified partnership, as described in subsections (f) to (m), inclusive, of this section, of such request and invite each qualified partnership in good standing to submit a bid proposal for such janitorial contract to the commissioner in a manner and form as prescribed by the commissioner; (2) in the event that only one such qualified partnership submits a bid for such janitorial contract, the commissioner shall award such contract to the bidding qualified partnership, provided such bid does not exceed the fair market value for such contract, as determined by the commissioner; (3) if more than one qualified partnership submits a bid, the commissioner shall award the contract to the lowest responsible qualified bidder, as defined in section 4a-59; and (4) in the event that a qualified partnership does not submit a bid or is not awarded such contract, the commissioner shall award such contract in accordance with the provisions of sections 4a-59 and 17b-656, as amended by this act.

(d) Notwithstanding any other provision of the general statutes, the responsibilities of the Commissioner of Administrative Services, as established in subsections (b) and (c) of this section, may not be delegated to an outside vendor.

(e) The Commissioner of Administrative Services may adopt regulations, in accordance with the provisions of chapter 54, to undertake the requirements established in subsections (b) to (e), inclusive, of this section.

(f) The Connecticut Community Providers Association shall designate a commercial janitorial contractor and a community rehabilitation program as a "qualified partnership" whenever the following criteria have been established: (1) Such commercial janitorial contractor has entered into a binding agreement with such community rehabilitation program in which such contractor agrees to fill not less than one-third of the jobs from a successful bid for a janitorial contract under the pilot program established in subsections (b) to (e), inclusive,

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of this section with persons with disabilities and not less than one-third of such jobs with persons with a disadvantage; (2) such contractor employs not less than two hundred persons who perform janitorial work in the state; and (3) such contractor certifies, in writing, that it will pay the standard wage to employees, including persons with disabilities, under such janitorial contract. Any partnership between a commercial janitorial contractor and a community rehabilitation program that has been denied designation as a qualified partnership may appeal such denial, in writing, to the Commissioner of Administrative Services and said commissioner may, after review of such appeal, designate such program as a qualified partnership.

(g) The requirement established in subsection (f) of this section to fill not less than one-third of the jobs from a successful bid for a janitorial contract with persons with disabilities and one-third with persons with a disadvantage shall be met whenever such janitorial contractor employs the requisite number of persons with disabilities and persons with a disadvantage throughout the entirety of its operations in the state provided any persons with disabilities employed by such janitorial contractor prior to the commencement date of any such contract shall not be counted for the purpose of determining the number of persons with disabilities employed by such janitorial contractor.

(h) The number of persons with disabilities and the number of persons with a disadvantage that such janitorial contractor is required to employ pursuant to the provisions of subsection (f) of this section shall be employed not later than six months after the commencement of janitorial work under the terms of any contract awarded pursuant to the provisions of subsections (b) to (e), inclusive, of this section, provided such contractor shall fill any vacancy for janitorial work that arises during the first six months of any such contract with persons with disabilities and persons with disadvantages.

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(i) The Connecticut Community Providers Association shall develop an application process and submit a list of employees who have applied to participate in a partnership to the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services for certification. Such association shall maintain a list of certified employees who are persons with disabilities and community rehabilitation programs.

(j) Any qualified partnership awarded a janitorial contract pursuant to the provisions of subsections (b) to (e), inclusive, of this section shall provide to the Connecticut Community Providers Association, not later than six months after the commencement date of such contract, a list of the persons with disabilities and persons with a disadvantage employed by such contractor that includes the date of hire and employment location for each such person. Such association shall certify to the Department of Administrative Services, in such manner and form as prescribed by the Commissioner of Administrative Services, that the requisite number of persons with disabilities for such contract continue to be employed by such contractor in positions equivalent to those created under such janitorial contract and have been integrated into the general workforce of such contractor.

(k) Notwithstanding any other provision of the general statutes, the responsibilities of the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services, as established in subsections (f) to (m), inclusive, of this section, may not be delegated to an outside vendor.

(l) The [Commissioner of Social Services] director of the Bureau of Rehabilitative Services may adopt regulations, in accordance with the provisions of chapter 54, to undertake the certification requirements established pursuant to subsections (f) to (m), inclusive, of this section.

(m) Notwithstanding the provisions of subsection (f) of this section, the Commissioner of Administrative Services shall authorize certified small and minority business to participate in such pilot program.

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(n) During the term of the pilot program described in subsections (b) to (e), inclusive, of this section, the joint standing committee of the General Assembly having cognizance of matters relating to government administration shall study the effectiveness of such pilot program, including, but not limited to, the effectiveness of such program to create integrated work settings for persons with disabilities. Additionally, said committee shall study the need to make such pilot program permanent and ways to provide incentives for municipalities and businesses to utilize such pilot program if such program is determined by the committee to be effective.

(o) During the term of the pilot program described in subsections (b) to (e), inclusive, of this section, any exclusive contract awarded pursuant to section 17b-656, as amended by this act, shall remain in effect with no changes in the formula for fair market value. Additionally, any new janitorial contract awarded pursuant to section 17b-656, as amended by this act, shall be limited to not more than four full-time employees per contract.

(p) Any person employed under a janitorial contract let: (1) On or before October 1, 2006, or thereafter if such contract constitutes a successor contract to such janitorial contract let on or before October 1, 2006, and (2) pursuant to section 4a-57 or 10a-151b or by the judicial or legislative departments or pursuant to subsections (b) to (e), inclusive, of this section shall have the same rights conferred upon an employee by section 31-57g for the duration of the pilot program described in subsections (b) to (e), inclusive, of this section. The provisions of this subsection shall not apply to any new janitorial contract with not more than four full-time employees per contract, as described in subsection (o) of this section.

Sec. 52. Subdivision (4) of subsection (a) of section 12-217oo of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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(4) "New qualifying employee" means a person who (A) is receiving vocational rehabilitation services from the [Bureau of Rehabilitation Services within the Department of Social Services or from the Board of Education and Services for the Blind] Bureau of Rehabilitative Services, and (B) is hired by the employer to fill a new job after May 6, 2010, during the employer's income years commencing on or after January 1, 2010. A new qualifying employee does not include a person receiving vocational rehabilitation services pursuant to subparagraph (A) of this subdivision and who was employed in this state by a related person with respect to the employer during the prior twelve months;

Sec. 53. Subsection (w) of section 5-198 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(w) Professional employees in the education professions bargaining unit of the [Bureau of Rehabilitation Services in the Department of Social Services] Bureau of Rehabilitative Services;

Sec. 54. Section 17b-612 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Department of Social Services] Bureau of Rehabilitative Services shall establish a program to assist disabled public school students in preparing for and obtaining competitive employment and to strengthen the linkage between vocational rehabilitation services and public schools. Under the program, the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services shall provide, within the limits of available appropriations, vocational evaluations and other appropriate transitional services and shall place vocational rehabilitation counselors in the following school districts: Hartford, West Hartford, Norwich, Bloomfield, Wethersfield and other school districts selected by the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services. The counselors shall, if requested, assist those

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persons planning in-school skill development programs. The counselors shall, with planning and placement team members, develop transition plans and individual education and work rehabilitation plans for disabled students who will no longer be eligible for continued public school services. Students whose termination date for receipt of public school services is most immediate shall be given priority.

Sec. 55. Section 17b-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [Bureau of Rehabilitation Services within the Department of Social Services] Bureau of Rehabilitative Services shall establish and maintain a state-wide network of centers for independent living.

(b) Not more than five per cent of the amount appropriated in any fiscal year for the purposes of this section may be used by the [Department of Social Services] Bureau of Rehabilitative Services to provide state-wide administration, evaluation and technical assistance relating to the implementation of this section.

Sec. 56. Subsection (b) of section 17b-615 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) The council shall meet regularly with the director of the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services and shall perform the following duties: (1) Issue an annual report by January first, with recommendations regarding independent living services and centers, to the Governor and the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to human services, and (2) consult with, advise and make recommendations to the [department] Bureau of Rehabilitative Services concerning independent living and related policy,

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management and budgetary issues.

Sec. 57. Section 17b-651a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Commissioner of Social Services] director of the Bureau of Rehabilitative Services shall inquire into the criminal history of any applicant, who is not at the time of application employed by the [Department of Social Services] Bureau of Rehabilitative Services, for a position of employment with the [department's] bureau's disability determination services unit. Such inquiry shall be conducted in accordance with the provisions of section 31-51i. The [commissioner] director shall require each such applicant to state whether the applicant has ever been convicted of a crime, whether criminal charges are pending against the applicant at the time of application, and, if so, to identify the charges and court in which such charges are pending. Each such applicant offered a position of employment with the [department's] bureau's disability determination services unit shall be required to submit to fingerprinting and state and national criminal history records checks, as provided in section 29-17a.

Sec. 58. Section 17b-653 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Vocational rehabilitation services shall be provided, with or without public cost, directly or through public or private instrumentalities, as part of an individual [written rehabilitation program] plan for employment for a person with disabilities determined to be eligible by the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services, in accordance with Title I of the Rehabilitation Act, 29 USC 701 et seq., as amended from time to time. Nothing in this section shall be construed to mean that an individual's ability or inability to share in the cost of vocational rehabilitative services may be taken into account during the determination of

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eligibility for such services.

(b) If vocational rehabilitation services cannot be provided for all eligible persons with disabilities who apply for such services, the [Department of Social Services] Bureau of Rehabilitative Services shall determine, in accordance with Title I of the Rehabilitation Act of 1973, 29 USC 701 et seq., and federal regulations, as amended from time to time, the order to be followed in selecting those to whom such services will be provided.

(c) Nothing in section 17b-650 or subsection (a) of this section shall be construed to preclude provision of vocational rehabilitation services, with or without public cost, to a person with a disability under an extended evaluation for a total period not in excess of eighteen months, in accordance with Title I of the Rehabilitation Act of 1973, 29 USC 701 et seq., as amended from time to time.

(d) The [Department of Social Services] director of the Bureau of Rehabilitative Services may adopt regulations in accordance with the provisions of chapter 54 to establish standards and procedures governing the provision of vocational rehabilitation services and, where appropriate, a means test to determine, based upon the financial need of each eligible person with disabilities, the extent to which such services will be provided at public cost. Any funds received by the [department] bureau from individuals or third parties for the provision of vocational rehabilitation services shall be used by the [department] bureau to provide such services. The regulations may also prescribe the procedures to be used when payment is made by individuals required to contribute to the cost of vocational rehabilitation services. Regulations developed to implement a means test shall include, but not be limited to: (1) An exemption for any individual with an income of less than one hundred per cent of the state median income and assets which are less than five thousand dollars; (2) an exemption for services covered in an individual [written

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rehabilitation program] plan for employment in effect at the time of implementation of the means test; (3) an exclusion from an individual's income of the costs of necessary and reasonable disability-related expenses including, but not limited to, personal attendant services and medications for which payment is unavailable to the individual through other benefits or resources; (4) an exclusion from the individual's assets of the value of the individual's primary residence and motor vehicle; (5) a method by which the director of the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services may reduce the level of required contributions by an individual in the case of undue hardship; and (6) a requirement that such bureau notify an individual of the results of the means test analysis within thirty days of receipt of necessary financial information from the individual. Such means test shall not apply to services covered under a determination of financial need made by an institution of higher education. The [Department of Social Services] Bureau of Rehabilitative Services shall develop the regulations in consultation with representatives of providers of vocational rehabilitation services and recipients of such services or their representatives.

Sec. 59. Subsection (b) of section 17b-654 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) Regardless of whether a person requests an informal review under subsection (a) of this section, any applicant for or recipient of vocational rehabilitation services who is aggrieved by a decision made by the [bureau] Bureau of Rehabilitative Services pursuant to section 17b-653, as amended by this act, may request an administrative hearing, by making written request to the director of the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services.

Sec. 60. Section 17b-655 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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(a) In carrying out sections 17b-650 to 17b-665, inclusive, as amended by this act, the [Department of Social Services] Bureau of Rehabilitative Services shall cooperate with other departments, agencies and institutions, both public and private, in providing for the vocational rehabilitation of persons with disabilities, in studying the problems involved therein and in establishing, developing and providing such programs, facilities and services as it deems necessary or desirable. Notwithstanding any other provisions of the general statutes to the contrary, the [Division of Rehabilitation Services] Bureau of Rehabilitative Services shall not be required to pay that portion of the cost of a program of postsecondary education or training which is properly designated as expected parental or family contribution in accordance with state and federal law regarding eligibility for student financial aid.

(b) Subject to the approval of all real estate acquisitions by the Commissioner of Public Works and the State Properties Review Board, in carrying out said sections, the [Department of Social Services] Bureau of Rehabilitative Services may (1) establish, operate, foster and promote the establishment of rehabilitation facilities and make grants to public and other nonprofit and nonsectarian organizations for such purposes; (2) assist persons with severe disabilities to establish and operate small businesses; and (3) make studies, investigations, demonstrations and reports, and provide training and instruction, including the establishment and maintenance of such research fellowships and traineeships with such stipends and allowances as may be deemed necessary, in matters relating to vocational rehabilitation.

(c) The [Commissioner of Social Services] director of the Bureau of Rehabilitative Services shall develop and maintain a program of public education and information. The program shall include, but not be limited to, education of the public concerning services available from

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the [Bureau of Rehabilitation Services] Bureau of Rehabilitative Services, its policies and goals, an outreach effort to discover persons with disabilities, including such persons who are minorities as defined in subsection (a) of section 32-9n, who may benefit from the services it offers and the dissemination of printed materials to persons at their initial meeting with staff of the bureau, including a statement of such person's rights. Each state agency providing services to persons with disabilities shall furnish to each person applying for such services, at the time of initial application, a written summary of all state programs for persons with disabilities. Such summary shall be developed by the Department of Social Services as the lead agency for services to persons with disabilities pursuant to section 17b-606. The Department of Social Services shall distribute sufficient copies of the summary to all state agencies providing services to persons with disabilities in order that such copies may be furnished in accordance with this subsection.

Sec. 61. Section 17b-657 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Department of Social Services is authorized, acting through the Bureau of Rehabilitation Services of said department,] Bureau of Rehabilitative Services is authorized to provide such medical, diagnostic, physical restoration, training and other rehabilitation services as may be needed to enable persons with disabilities to attain the maximum degree of self care. The powers herein delegated and authorized to the [Department of Social Services] Bureau of Rehabilitative Services shall be in addition to those authorized by any other law and shall become effective upon authorization of federal grant-in-aid funds for participation in the cost of independent living rehabilitation services for persons with disabilities. The [Department of Social Services] Bureau of Rehabilitative Services shall be authorized to cooperate with whatever federal agency is directed to administer the

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federal aspects of such program and to comply with such requirements and conditions as may be established for the receipt and disbursement of federal grant-in-aid funds which may be made available to the state of Connecticut in carrying out such program.

Sec. 62. Section 17b-658 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Department of Social Services] Bureau of Rehabilitative Services is authorized to cooperate with the federal government in carrying out the purposes of any federal statutes pertaining to vocational rehabilitation, to adopt such methods of administration as it finds necessary for the proper and efficient operation of agreements or plans for vocational rehabilitation and to comply with such conditions as may be necessary to secure the full benefits of such federal statutes to this state.

Sec. 63. Section 17b-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The State Treasurer is designated as the custodian of all funds received from the federal government for the purpose of carrying out any federal statutes pertaining to vocational rehabilitation or any agreements authorized by sections 17b-650 to 17b-663, inclusive, as amended by this act, and shall make disbursements from such funds and from all state funds available for vocational rehabilitation purposes [, except for services to the blind,] upon certification by the [Commissioner of Social Services] director of the Bureau of Rehabilitative Services.

Sec. 64. Section 17b-660 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The [Commissioner of Social Services] director of the Bureau of Rehabilitative Services is authorized to accept and use gifts made

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unconditionally by will or otherwise for carrying out the purposes of [sections 17b-650 to 17b-663, inclusive] the general statutes concerning the Bureau of Rehabilitative Services. Gifts made under such conditions as in the judgment of the [Commissioner of Social Services] director of the Bureau of Rehabilitative Services are proper and consistent with the provisions of said sections may be so accepted and shall be held, invested, reinvested and used in accordance with the conditions of the gift.

Sec. 65. Section 17b-661 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Notwithstanding any other provision of the general statutes, the [Bureau of Rehabilitation Services of the Department of Social Services] Bureau of Rehabilitative Services may, within the limits of appropriations, purchase (1) wheelchairs and placement equipment directly and without the issuance of a purchase order, provided such purchases shall not be in excess of three thousand five hundred dollars per unit purchased, and (2) adaptive equipment and modified vehicles for persons with disabilities directly and without the issuance of a purchase order, provided such purchases of adaptive equipment shall not be in excess of ten thousand dollars per unit purchased and such purchases of modified vehicles shall not be in excess of twenty-five thousand dollars per vehicle. All such purchases shall be made in the open market, but shall, when possible, be based on at least three competitive bids. Such bids shall be solicited by sending notice to prospective suppliers and by posting notice on a public bulletin board within [said Bureau of Rehabilitation Services] the Bureau of Rehabilitative Services. Each bid shall be opened publicly at the time stated in the notice soliciting such bid. Acceptance of a bid by [said Bureau of Rehabilitation Services] the Bureau of Rehabilitative Services shall be based on standard specifications as may be adopted by said bureau.

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Sec. 66. Section 17b-665 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

On July 1, [1991] 2011, and annually thereafter, the [Department of Social Services shall report] Bureau of Rehabilitative Services shall submit to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies [concerning (1) the plans of the department to reduce the case loads of counselors of the Bureau of Rehabilitation Services to reflect the regional average for counselor case loads, (2) client information, including, but not limited to, the age, race, gender, nature of disabilities, placements and statistics on job retention and on the number of persons with disabilities in the state, (3) the department's efforts to insure that the proportion of disabled persons who are minorities, as defined in subsection (a) of section 32-9n, and who are served by the bureau is equivalent to the proportion of minorities within the total disabled population of the state and (4) the number, nature and resolution of complaints received by the bureau. The department shall provide each committee with a copy of the federal audit of the Bureau of Rehabilitation Services and in its initial report, the department shall advise the committees concerning the cost of the transfer from the Department of Education to the Department of Social Services] the data the bureau provides to the federal government that relates to the evaluation standards and performance indicators for the vocational rehabilitation services program.

Sec. 67. Section 17b-666 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [Bureau of Rehabilitation Services of the Department of Social Services] Bureau of Rehabilitative Services may receive state and federal funds to administer, within available appropriations, an employment opportunities program to serve individuals with the most

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significant disabilities who do not meet the eligibility requirements of supported employment programs administered by the Departments of Developmental Services and Mental Health and Addiction Services. For the purposes of this section, "individuals with the most significant disabilities" means those individuals who (1) have serious employment limitations in a total of three or more functional areas including, but not limited to, mobility, communication, self-care, interpersonal skills, work tolerance or work skills, or (2) will require significant ongoing disability-related services on the job in order to maintain employment.

(b) The employment opportunities program shall provide extended services, as defined in 34 CFR 361.5(b)(19), that are necessary for individuals with the most significant disabilities to maintain supported employment. Such services shall include coaching and other related services that allow participants to obtain and maintain employment and maximize economic self-sufficiency.

(c) The [Department of Social Services] Bureau of Rehabilitative Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section.

Sec. 68. (*Effective July 1, 2011*) Not later than January 2, 2012, the director of the Bureau of Rehabilitative Services shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services concerning: (1) The status of the merger of the operations and finances of the Commission on the Deaf and Hearing Impaired, the Board of Education and Services for the Blind and the Bureau of Rehabilitation Services of the Department of Social Services and the integration of functions previously performed by the Department of Motor Vehicles and the Workers' Compensation Commission in accordance with the provisions of the general statutes concerning the Bureau of

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Rehabilitative Services; (2) the organizational structure of the bureau; (3) the place or places of the bureau's operations; and (4) any recommendations for further legislative action concerning such merger including, but not limited to, recommendations to increase the efficiency of the Bureau of Rehabilitative Services' operations and to achieve cost savings.

Sec. 69. (*Effective from passage*) Notwithstanding the provisions of section 60 of public act 05-251, effective January 1, 2012, the personnel, payroll, administrative action and business office functions of the Board of Education and Services for the Blind and the Commission on the Deaf and Hearing Impaired shall no longer be merged and consolidated into the Department of Administrative Services and will be assumed by the Bureau of Rehabilitative Services, provided the director of the Bureau of Rehabilitative Services may extend the effective date for the transfer of functions for six months, to June 30, 2012, by submitting a written notice to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

Sec. 70. Subsection (a) of section 17b-93 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) If a beneficiary of aid under the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program or state-administered general assistance program has or acquires property of any kind or interest in any property, estate or claim of any kind, except moneys received for the replacement of real or personal property, the state of Connecticut shall have a claim subject to subsections (b) and (c) of this section, which shall have priority over all other unsecured claims and unrecorded encumbrances, against such beneficiary for the full amount paid, subject to the provisions of section 17b-94, as amended

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by this act, to [him] the beneficiary or on [his] the beneficiary's behalf under said programs; and, in addition thereto, the parents of an aid to dependent children beneficiary, a state-administered general assistance beneficiary or a temporary family assistance beneficiary shall be liable to repay, subject to the provisions of [said] section 17b-94, as amended by this act, to the state the full amount of any such aid paid to or on behalf of either parent, [his] the beneficiary's spouse, and [his] the beneficiary's dependent child or children, as defined in section 17b-75. The state of Connecticut shall have a lien against property of any kind or interest in any property, estate or claim of any kind of the parents of an aid to dependent children, temporary family assistance or state administered general assistance beneficiary, in addition and not in substitution of its claim, for amounts owing under any order for support of any court or any family support magistrate, including any arrearage under such order, provided household goods and other personal property identified in section 52-352b, real property pursuant to section 17b-79, as long as such property is used as a home for the beneficiary and money received for the replacement of real or personal property, shall be exempt from such lien.

Sec. 71. Section 17b-94 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) In the case of causes of action of beneficiaries of aid under the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program or state-administered general assistance program, subject to subsections (b) and (c) of section 17b-93, as amended by this act, or of a parent [of a beneficiary of the aid to families with dependent children program, the temporary family assistance program or the state-administered general assistance program] liable to repay the state under the provisions of section 17b-93, as amended by this act, the claim of the state shall be a lien against the proceeds therefrom in the

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amount of the assistance paid or fifty per cent of the proceeds received by such beneficiary or such parent after payment of all expenses connected with the cause of action, whichever is less, for repayment under [said] section 17b-93, as amended by this act, and shall have priority over all other claims except attorney's fees for said causes, expenses of suit, costs of hospitalization connected with the cause of action by whomever paid over and above hospital insurance or other such benefits, and, for such period of hospitalization as was not paid for by the state, physicians' fees for services during any such period as are connected with the cause of action over and above medical insurance or other such benefits; and such claim shall consist of the total assistance repayment for which claim may be made under said programs. The proceeds of such causes of action shall be assignable to the state for payment of the amount due under [said] section 17b-93, as amended by this act, irrespective of any other provision of law. Upon presentation to the attorney for the beneficiary of an assignment of such proceeds executed by the beneficiary or his conservator or guardian, such assignment shall constitute an irrevocable direction to the attorney to pay the Commissioner of Administrative Services in accordance with its terms, except if, after settlement of the cause of action or judgment thereon, the Commissioner of Administrative Services does not inform the attorney for the beneficiary of the amount of lien which is to be paid to the Commissioner of Administrative Services within forty-five days of receipt of the written request of such attorney for such information, such attorney may distribute such proceeds to such beneficiary and shall not be liable for any loss the state may sustain thereby.

(b) In the case of an inheritance of an estate by a beneficiary of aid under the state supplement program, medical assistance program, aid to families with dependent children program, temporary family assistance program or state-administered general assistance program, subject to subsections (b) and (c) of section 17b-93, as amended by this

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act, or by a parent liable to repay the state under the provisions of section 17b-93, as amended by this act, fifty per cent of the assets of the estate payable to the beneficiary or such parent or the amount of such assets equal to the amount of assistance paid, whichever is less, shall be assignable to the state for payment of the amount due under [said] section 17b-93, as amended by this act. The state shall have a lien against such assets in the applicable amount specified in this subsection. The Court of Probate shall accept any such assignment executed by the beneficiary or parent or any such lien notice if such assignment or lien notice is filed by the Commissioner of Administrative Services with the court prior to the distribution of such inheritance, and to the extent of such inheritance not already distributed, the court shall order distribution in accordance [therewith] with such assignment or lien notice. If the Commissioner of Administrative Services receives any assets of an estate pursuant to any such assignment, the commissioner shall be subject to the same duties and liabilities concerning such assigned assets as the beneficiary or parent.

Sec. 72. Section 17b-224 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

A patient who is receiving or has received care in a state humane institution, his estate or both shall be liable to reimburse the state for any unpaid portion of per capita cost to the same extent as the liability of a public assistance beneficiary under sections 17b-93, as amended by this act, and 17b-95, subject to the same protection of a surviving spouse or dependent child as is [therein] provided in section 17b-95 and subject to the same limitations and the same assignment and lien rights as provided in section 17b-94, as amended by this act.

Sec. 73. Subdivision (4) of subsection (f) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

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(4) For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated with a wage, benefit and staffing enhancement rate adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the

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fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (15) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one-half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a

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lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, for the fiscal year ending June 30, 2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005, as provided under section 17-311-55 of the regulations of Connecticut state agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006, shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by eleven dollars and eighty cents per day except that in no event shall the rate for the period ending June 30, 2006, be thirty-two dollars more than the rate in effect for the period ending June 30, 2005,

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and for any facility with a rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with a rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. For each facility with an interim rate for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven dollars and eighty cents per day plus the per day cost of the user fee payments made pursuant to section 17b-320 divided by annual resident service days, except for any facility with an interim rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with an interim rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, each facility shall receive a rate that is three per cent greater than the rate in effect for the period ending June 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths

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per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent, except for the fiscal [year] years ending June 30, 2010, [and the fiscal year ending] June 30, 2011, June 30, 2012, and June 30, 2013, such fair rent increases shall only be provided to facilities with an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to licensed chronic and convalescent nursing homes and licensed rest homes with nursing supervision.

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Sec. 74. Subsection (g) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(g) For the fiscal year ending June 30, 1993, any intermediate care facility for the mentally retarded with an operating cost component of its rate in excess of one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any intermediate care facility for the mentally retarded with an operating cost component of its rate that is less than one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to thirty per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut

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state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Developmental Services, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June

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30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is four per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than three per cent greater than the rate in effect for the facility on September 30, 2006, except any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status, or agreement with the department,

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shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to intermediate care facilities for the mentally retarded.

Sec. 75. Subdivision (1) of subsection (h) of section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost

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component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall

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be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate

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increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate, except (i) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (ii) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the

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provisions of section 19a-495a, as amended by this act, concerning the administration of medication by unlicensed personnel. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except that (I) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (II) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355.

Sec. 76. Subsection (a) of section 17b-280 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The state shall reimburse for all legend drugs provided under [the Medicaid, state-administered general assistance, ConnPACE and Connecticut AIDS drug assistance programs] medical assistance programs administered by the Department of Social Services at the lower of (1) the rate established by the Centers for Medicare and Medicaid Services as the federal acquisition cost, (2) the average wholesale price minus [fourteen] sixteen per cent, or (3) an equivalent percentage as established under the Medicaid state plan. The [commissioner] state shall [also establish] pay a professional fee of two dollars [and ninety cents] to licensed pharmacies for each prescription [to be paid to licensed pharmacies for dispensing drugs to Medicaid, state-administered general assistance, ConnPACE and Connecticut

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AIDS drug assistance recipients] dispensed to a recipient of benefits under a medical assistance program administered by the Department of Social Services in accordance with federal regulations. [; and on] On and after September 4, 1991, payment for legend and nonlegend drugs provided to Medicaid recipients shall be based upon the actual package size dispensed. Effective October 1, 1991, reimbursement for over-the-counter drugs for such recipients shall be limited to those over-the-counter drugs and products published in the Connecticut Formulary, or the cross reference list, issued by the commissioner. The cost of all over-the-counter drugs and products provided to residents of nursing facilities, chronic disease hospitals, and intermediate care facilities for the mentally retarded shall be included in the facilities' per diem rate. Notwithstanding the provisions of this subsection, no dispensing fee shall be issued for a prescription drug dispensed to a ConnPACE or Medicaid recipient who is a Medicare Part D beneficiary when the prescription drug is a Medicare Part D drug, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 77. Subsection (b) of section 17b-104 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) On July 1, 2007, and annually thereafter, the commissioner shall increase the payment standards over those of the previous fiscal year under the temporary family assistance program and the state-administered general assistance program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the payment standards for the fiscal years ending June 30, 2010, [and] June 30, 2011, June 30, 2012, and June 30, 2013, shall not be increased.

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Sec. 78. Section 17b-106 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) On January 1, 2006, and on each January first thereafter, the Commissioner of Social Services shall increase the unearned income disregard for recipients of the state supplement to the federal Supplemental Security Income Program by an amount equal to the federal cost-of-living adjustment, if any, provided to recipients of federal Supplemental Security Income Program benefits for the corresponding calendar year. On July 1, 1989, and annually thereafter, the commissioner shall increase the adult payment standards over those of the previous fiscal year for the state supplement to the federal Supplemental Security Income Program by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous calendar year, provided the annual increase, if any, shall not exceed five per cent, except that the adult payment standards for the fiscal years ending June 30, 1993, June 30, 1994, June 30, 1995, June 30, 1996, June 30, 1997, June 30, 1998, June 30, 1999, June 30, 2000, June 30, 2001, June 30, 2002, June 30, 2003, June 30, 2004, June 30, 2005, June 30, 2006, June 30, 2007, June 30, 2008, June 30, 2009, June 30, 2010, [and] June 30, 2011, June 30, 2012, and June 30, 2013, shall not be increased. Effective October 1, 1991, the coverage of excess utility costs for recipients of the state supplement to the federal Supplemental Security Income Program is eliminated. Notwithstanding the provisions of this section, the commissioner may increase the personal needs allowance component of the adult payment standard as necessary to meet federal maintenance of effort requirements.

(b) Effective July 1, [1998] 2011, the commissioner shall provide a state supplement payment for recipients of Medicaid and the federal Supplemental Security Income Program who reside in long-term care facilities sufficient to increase their personal needs allowance to [fifty]

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sixty dollars per month. Such state supplement payment shall be made to the long-term care facility to be deposited into the personal fund account of each such recipient. [Effective July 1, 1999, and annually thereafter, the commissioner shall increase such allowance to reflect the annual inflation adjustment in Social Security income, if any.] For the purposes of this subsection, "long-term care facility" means a licensed chronic and convalescent nursing home, a chronic disease hospital, a rest home with nursing supervision, an intermediate care facility for the mentally retarded or a state humane institution.

Sec. 79. Section 17b-272 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Effective July 1, [1998] 2011, the Commissioner of Social Services shall permit patients residing in nursing homes, chronic disease hospitals and state humane institutions who are medical assistance recipients under sections 17b-260 to 17b-262, inclusive, as amended by this act, 17b-264 to 17b-285, inclusive, as amended by this act, and 17b-357 to 17b-361, inclusive, to have a monthly personal fund allowance of [fifty] sixty dollars. [Effective July 1, 1999, the commissioner shall increase such allowance annually to reflect the annual inflation adjustment in Social Security income, if any.]

Sec. 80. Section 17b-311 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective September 1, 2011*):

(a) There is established the Charter Oak Health Plan for the purpose of providing access to health insurance coverage for state residents who have been uninsured for at least six months, [and] who are ineligible for other publicly funded health insurance plans and who are ineligible for the high-risk pool established pursuant to Section 1101 of the Patient Protection and Affordable Care Act, P.L. 111-148. The Commissioner of Social Services may enter into contracts for the provision of comprehensive health care for such uninsured state

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residents. The commissioner shall conduct outreach to facilitate enrollment in the plan.

(b) The commissioner shall impose cost-sharing requirements in connection with services provided under the Charter Oak Health Plan. Such requirements may include, but not be limited to: (1) A monthly premium; (2) an annual deductible not to exceed one thousand dollars; (3) a coinsurance payment not to exceed twenty per cent after the deductible amount is met; (4) tiered copayments for prescription drugs determined by whether the drug is generic or brand name, formulary or nonformulary and whether purchased through mail order; (5) no fee for emergency visits to hospital emergency rooms; (6) a copayment not to exceed one hundred fifty dollars for nonemergency visits to hospital emergency rooms; and (7) a lifetime benefit not to exceed one million dollars.

(c) (1) The Commissioner of Social Services shall provide premium assistance to eligible state residents whose gross annual income does not exceed three hundred per cent of the federal poverty level. Such premium assistance shall be limited to: (A) One hundred [seventy-five] fifteen dollars per month for individuals whose gross annual income is below one hundred fifty per cent of the federal poverty level; (B) one hundred [fifty] dollars per month for individuals whose gross annual income is at or above one hundred fifty per cent of the federal poverty level but not more than one hundred eighty-five per cent of the federal poverty level; (C) [seventy-five] fifty dollars per month for individuals whose gross annual income is above one hundred eighty-five per cent of the federal poverty level but not more than two hundred thirty-five per cent of the federal poverty level; and (D) [fifty] thirty-five dollars per month for individuals whose gross annual income is above two hundred thirty-five per cent of the federal poverty level but not more than three hundred per cent of the federal poverty level. Individuals insured under the Charter Oak Health Plan shall pay their share of

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payment for coverage in the plan directly to the insurer.

(2) Notwithstanding the provisions of this subsection, for the fiscal years ending June 30, 2010, [and] June 30, 2011, and each fiscal year thereafter, the Commissioner of Social Services shall only provide premium assistance to state residents who are eligible for such assistance and who are enrolled in the Charter Oak Health Plan on [April 30, 2010] May 31, 2010.

(d) The Commissioner of Social Services shall determine minimum requirements on the amount, duration and scope of benefits under the Charter Oak Health Plan. [, except that there shall be no preexisting condition exclusion.] Each participating insurer or administrative services organization shall provide an internal grievance process by which an enrollee in the Charter Oak Health Plan may request and be provided a review of a denial of coverage under the plan.

(e) The Commissioner of Social Services shall seek proposals from entities described in subsection (e) of this section based on the cost sharing and benefits described in subsections (b) and (c) of this section. The commissioner may approve an alternative plan in order to make coverage options available to those eligible to be insured under the plan.

(f) The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies shall be valid until the time final regulations are adopted and may include: (1) Exceptions to the requirement that a resident be uninsured for at least six months to be eligible for the Charter Oak Health Plan; and (2) requirements for open enrollment and limitations on the ability

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of enrollees to change plans between such open enrollment periods.

Sec. 81. (NEW) (*Effective July 1, 2011*) (a) The Commissioner of Social Services shall modify the extent of nonemergency adult dental services provided under the Medicaid program. Such modifications shall include, but are not limited to, providing one periodic dental exam, one dental cleaning and one set of bitewing x-rays each year for a healthy adult. For purposes of this section, "healthy adult" means a person over twenty-one years of age for whom there is no evidence indicating that dental disease is an aggravating factor for the person's overall health condition.

(b) The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall remain valid for three years following the date of publication in the Connecticut Law Journal unless otherwise provided for by the General Assembly. Notwithstanding the time frames established in subsection (c) of section 17b-10 of the general statutes, the commissioner shall submit such policies and procedures in proposed regulation form to the legislative regulation review committee not later than three years following the date of publication of its intent to adopt regulations as provided for in this subsection. In the event that the commissioner is unable to submit proposed regulations prior to the expiration of the three-year time period as provided for in this subsection, the commissioner shall submit written notice, not later than thirty-five days prior to the date of expiration of such time period, to the legislative regulation review committee and the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state

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agencies indicating that the department will not be able to submit the proposed regulations on or before such date and shall include in such notice (1) the reasons why the department will not submit the proposed regulations by such date, and (2) the date by which the department will submit the proposed regulations. The legislative regulation review committee may require the department to appear before the committee at a time prescribed by the committee to further explain such reasons and to respond to any questions by the committee about the policy. The legislative regulation review committee may request the joint standing committee of the General Assembly having cognizance of matters relating to human services to review the department's policy, the department's reasons for not submitting the proposed regulations by the date specified in this section and the date by which the department will submit the proposed regulations. Said joint standing committee may review the policy, such reasons and such date, may schedule a hearing thereon and may make a recommendation to the legislative regulation review committee.

Sec. 82. Subsection (a) of section 17b-244 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The room and board component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as intermediate care facilities for persons with mental retardation, shall be determined annually by the Commissioner of Social Services, except that rates effective April 30, 1989, shall remain in effect through October 31, 1989. Any facility with real property other than land placed in service prior to July 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real

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property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding July 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request by such facility, allow actual debt service, comprised of principal and interest, on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. In the case of facilities financed through the Connecticut Housing Finance Authority, the commissioner shall allow actual debt service, comprised of principal, interest and a reasonable repair and replacement reserve on the loan or loans in lieu of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, whether actual debt service is higher or lower than such allowed property costs, provided such debt service terms and amounts are determined by the commissioner at the time the loan is entered into to be reasonable in relation to the useful life and base value of the property. The commissioner may allow fees associated with mortgage refinancing provided such refinancing will result in state reimbursement savings, after comparing costs over the terms of the existing proposed loans. For the fiscal year ending June 30, 1992, the inflation factor used to determine rates shall be one-half of the gross national product percentage increase for the period between the midpoint of the cost year through the midpoint of the rate year. For fiscal year ending June 30, 1993, the inflation factor used to determine rates shall be two-thirds of the gross national product percentage increase from the midpoint of the cost year to the midpoint of the rate year. For the fiscal years ending June 30, 1996, and June 30, 1997, no inflation factor shall be applied in determining rates. The Commissioner of Social Services shall prescribe uniform forms on

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which such facilities shall report their costs. Such rates shall be determined on the basis of a reasonable payment for necessary services. Any increase in grants, gifts, fund-raising or endowment income used for the payment of operating costs by a private facility in the fiscal year ending June 30, 1992, shall be excluded by the commissioner from the income of the facility in determining the rates to be paid to the facility for the fiscal year ending June 30, 1993, provided any operating costs funded by such increase shall not obligate the state to increase expenditures in subsequent fiscal years. Nothing contained in this section shall authorize a payment by the state to any such facility in excess of the charges made by the facility for comparable services to the general public. The service component of the rates to be paid by the state to private facilities and facilities operated by regional education service centers which are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid programs as intermediate care facilities for persons with mental retardation, shall be determined annually by the Commissioner of Developmental Services in accordance with section 17b-244a. For the fiscal year ending June 30, 2008, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, no facility shall receive a rate that is more than two per cent greater than the rate in effect for the facility on June 30, 2008, except any facility that would have been issued a lower rate effective July 1, 2008, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2008. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except that (1) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2009, if a capital

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improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal years ending June 30, 2010, or June 30, 2011, and (2) any facility that would have been issued a lower rate for the fiscal years ending June 30, 2010, or June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except that (1) the rate paid to a facility may be higher than the rate paid to the facility for the period ending June 30, 2011, if a capital improvement required by the Commissioner of Developmental Services for the health or safety of the residents was made to the facility during the fiscal years ending June 30, 2012, or June 30, 2013, and (2) any facility that would have been issued a lower rate for the fiscal years ending June 30, 2012, or June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate.

Sec. 83. (*Effective from passage*) Not later than July 1, 2012, the Commissioner of Social Services shall report, in accordance with the provisions of section 11-4a of the general statutes, to the legislative regulation review committee and to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies concerning the Department of Social Services' regulation process and the status of policies and procedures implemented by the department for which proposed regulations have not been submitted to the legislative regulation review committee including, but not limited to, the policies and procedures implemented pursuant to sections 81, 110, 116 and 160 of this act. Such report shall include, but not be limited to: (1) The number and a description of the duties of department staff assigned to work on proposed regulations; (2) the need, if any, for additional staff and a description of the duties such new employees are

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expected to perform; (3) a timetable for training any new department employees to assist in the regulation process; (4) a description of the systems supports utilized and needed to assist with the efficiency and delivery of proposed regulations, if any; (5) a description of policies and procedures implemented by the department for which proposed regulations have not been submitted to the legislative regulation review committee, including, but not limited to, the dates on which such policies and procedures were implemented; and (6) a timetable for submitting such proposed regulations to the legislative regulation review committee.

Sec. 84. Subsection (d) of section 17b-265 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(d) When a recipient of medical assistance has personal health insurance in force covering care or other benefits provided under such program, payment or part-payment of the premium for such insurance may be made when deemed appropriate by the Commissioner of Social Services. Effective January 1, 1992, the commissioner shall limit reimbursement to medical assistance providers, except those providers whose rates are established by the Commissioner of Public Health pursuant to chapter 368d, for coinsurance and deductible payments under Title XVIII of the Social Security Act to assure that the combined Medicare and Medicaid payment to the provider shall not exceed the maximum allowable under the Medicaid program fee schedules. For those providers whose rates are established by the Commissioner of Public Health pursuant to chapter 368d, the Commissioner of Social Services shall limit reimbursement for coinsurance and deductible payments under Title XVIII of the Social Security Act to assure that the combined Medicare and Medicaid payment to the provider does not exceed the maximum allowable under the Medicaid program fee schedules plus a percentage established by the Commissioner of Social

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Services.

Sec. 85. Section 17b-28e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Commissioner of Social Services shall amend the Medicaid state plan to include, on and after January 1, 2009, hospice services as optional services covered under the Medicaid program. Said state plan amendment shall supersede any regulations of Connecticut state agencies concerning such optional services.

(b) [Not later than February 1, 2011] Effective July 1, 2013, the Commissioner of Social Services shall amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program. Not later than [February 1, 2011] July 1, 2013, the commissioner shall develop and implement the use of medical billing codes for foreign language interpreter services. [for the HUSKY Plan, Part A and Part B, and for the fee-for-services Medicaid programs.]

(c) [Each care management organization that enters into a contract with] Effective July 1, 2013, the Department of Social Services [to provide foreign language interpreter services under the HUSKY Plan, Part A] shall report, in accordance with the provisions of section 11-4a, semi-annually, to the [department] Council on Medical Assistance Program Oversight on the foreign language interpreter services provided to recipients of benefits under the program. [Such written reports shall be submitted to the department not later than June first and December thirty-first each year. Not later than thirty days after receipt of such report, the department shall submit a copy of the report, in accordance with the provisions of section 11-4a, to the Council on Medicaid Care Management Oversight.]

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(d) Not later than October 1, 2011, the Commissioner of Social Services shall amend the Medicaid state plan to include podiatry as an optional service under the Medicaid program.

Sec. 86. Subdivisions (1) and (2) of subsection (i) of section 17b-342 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(i) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the program for persons (A) who are sixty-five years of age and older; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets, if single, do not exceed one hundred fifty per cent of the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e, as provided in subdivision (3) of this subsection, any person whose income is at or below two hundred per cent of the federal poverty level and who is ineligible for Medicaid shall contribute [six] seven per cent of the cost of his or her care. Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute [six] seven per cent of the cost of his or her care in addition to the amount of applied income determined in accordance with the

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methodology established by the Department of Social Services for recipients of medical assistance. Any person who does not contribute to the cost of care in accordance with this subdivision, shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

Sec. 87. Section 47 of public act 11-6 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Notwithstanding the provisions of section 4-28e of the general statutes, for each of the fiscal years ending June 30, 2012, and June 30, 2013, the sum of \$1,450,000 shall be transferred from the Tobacco and Health Trust Fund to the Department of Public Health, for (1) grants for the Easy Breathing Program, as follows: (A) For an adult asthma program within the Easy Breathing Program - \$300,000, and (B) for a children's asthma program within the Easy Breathing Program - \$500,000, (2) a grant to the Connecticut Coalition for Environmental Justice for the Community Asthma Education Program - \$150,000, and (3) [grants to] regional [councils for] emergency medical services - \$500,000.

(b) Notwithstanding section 4-28e of the general statutes, the sum of \$2,750,000 for the fiscal year ending June 30, 2012, and the sum of \$3,400,000 for the fiscal year ending June 30, 2013, shall be transferred from the Tobacco and Health Trust Fund to the Department of Social Services, for Medicaid, to support smoking cessation programs.

Sec. 88. Section 17b-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

As used in sections 17b-490 to 17b-498, inclusive, as amended by

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this act:

(a) "Pharmacy" means a pharmacy licensed under section 20-594 or a pharmacy located in a health care institution, as defined in subsection (a) of section 19a-490, which elects to participate in the program;

(b) "Prescription drugs" means (1) legend drugs, as defined in section 20-571, (2) any other drugs which by state law or regulation require the prescription of a licensed practitioner for dispensing, except: (A) Products prescribed for cosmetic purposes as specified in regulations adopted pursuant to section 17b-494; (B) on and after September 15, 1991, diet pills, smoking cessation gum, contraceptives, multivitamin combinations, cough preparations and antihistamines; (C) drugs for the treatment of erectile dysfunction, unless such drug is prescribed to treat a condition other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration; and (D) drugs for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety pursuant to chapter 969, and (3) insulin and insulin syringes;

(c) "Reasonable cost" means the cost of the prescription drug determined in accordance with the formula adopted by the Commissioner of Social Services in regulations for medical assistance purposes plus a dispensing fee equal to the fee determined by said commissioner for medical assistance purposes;

(d) "Resident" means a person legally domiciled within the state for a period of not less than one hundred eighty-three days immediately preceding the date of application for inclusion in the program. Mere seasonal or temporary residences within the state, of whatever duration, shall not constitute domicile;

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(e) "Disabled" means a person over eighteen years of age who is receiving disability payments pursuant to either Title 2 or Title 16 of the Social Security Act of 1935, as amended;

(f) "Commissioner" means the Commissioner of Social Services;

(g) "Income" means adjusted gross income as determined for purposes of the federal income tax plus any other income of such person not included in such adjusted gross income. [minus Medicare Part B premium payments.] The amount of any Medicaid payments made on behalf of such person or the spouse of such person shall not constitute income;

(h) "Program" means the Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled Program otherwise known as ConnPACE;

(i) "Pharmaceutical manufacturer" means any entity holding legal title to or possession of a national drug code number issued by the federal Food and Drug Administration;

(j) "Average manufacturer price" means the average price paid by a wholesaler to a pharmaceutical manufacturer, after the deduction of any customary prompt payment discounts, for a product distributed for retail sale. [;]

[(k) "Assets" means a person's resources, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

(l) "Low income subsidy" means a premium and cost-sharing subsidy for low-income individuals, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

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(m) "Medicare Part D covered prescription drugs" means drugs that are included in Medicare Part D plan's formulary or are treated as being included in a Medicare Part D plan's formulary, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003;

(n) "Medicare Part D plan" means a Medicare Part D plan, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

(o) "Gap in standard Medicare Part D coverage" means a drug obtained after a Medicare Part D beneficiary's initial coverage limit has been exceeded but before the beneficiary's annual out-of-pocket threshold has been met, as defined by Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.]

Sec. 89. Section 17b-492 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Eligibility for participation in the program shall be limited to any resident (1) who is sixty-five years of age or older or who is disabled, (2) whose current annual income at the time of application or redetermination, if unmarried, is less than twenty thousand eight hundred dollars or whose annual income, if married, when combined with that of the resident's spouse is less than twenty-eight thousand one hundred dollars, (3) who is not eligible for Medicare or insured under a policy which provides full or partial coverage for prescription drugs once a deductible is met, [except for a Medicare prescription drug discount card endorsed by the Secretary of Health and Human Services in accordance with Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or coverage under Medicare Part D pursuant to said act,] and (4) on and after September 15, 1991, who pays an annual forty-five-dollar

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registration fee to the Department of Social Services. On January 1, 2012, and annually thereafter, the commissioner shall increase the income limits established under this subsection over those of the previous fiscal year to reflect the annual inflation adjustment in Social Security income, if any. Each such adjustment shall be determined to the nearest one hundred dollars. On and after October 1, 2009, new applications to participate in the ConnPACE program may be accepted only from the fifteenth day of November through the thirty-first day of December each year, except that individuals may apply within thirty-one days of (A) reaching sixty-five years of age, or (B) becoming eligible for Social Security Disability Income or Supplemental Security Income.

(b) (1) Payment for a prescription under the program shall be made only if no other plan of insurance or assistance is available to an eligible person for such prescription at the time of dispensing. [, except for benefits received from an endorsed Medicare prescription drug discount card or benefits provided under Medicare Part D.] The pharmacy shall make reasonable efforts to ascertain the existence of other insurance or assistance. [, including the subsidy provided by an endorsed Medicare prescription drug discount card or benefits provided under Medicare Part D. A Medicare prescription drug discount card beneficiary shall be responsible for the payment of any Medicare prescription drug discount card coinsurance requirements, provided such requirements do not exceed the ConnPACE program copayment requirements. If a Medicare prescription drug discount card beneficiary's coinsurance requirements exceed the ConnPACE copayment requirements, the Department of Social Services shall make payment to the pharmacy to cover costs in excess of the ConnPACE copayment amount. If the cost to such beneficiary exceeds the remaining available Medicare prescription drug discount card subsidy, the beneficiary shall not be responsible for any payment in excess of the amount of the ConnPACE program copayment requirement. In

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such cases, the Department of Social Services shall make payment to the pharmacy to cover costs in excess of the ConnPACE copayment amount.]

[(2) A Medicare Part D beneficiary shall be responsible for the payment of Medicare Part D copayments, coinsurance and deductible requirements for Medicare-Part-D-covered prescription drugs, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, to the extent such requirements do not exceed the ConnPACE program copayment requirements. The Department of Social Services shall pay Medicare Part D monthly beneficiary premiums on behalf of the beneficiary. If a Medicare Part D beneficiary's out-of-pocket copayment, coinsurance or deductible requirements exceed the ConnPACE copayment requirements, the department shall make payment to the pharmacy to cover costs in excess of the ConnPACE copayment amount. The department shall be responsible for payment of a Medicare-Part-D-covered prescription drug obtained during the gap in standard Medicare Part D coverage. To the extent permitted under said act, such payment may be made by the department for a prescription at (A) the lower of the price that would be paid under the ConnPACE program or the negotiated price established by the beneficiary's Medicare Part D plan pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or (B) in consultation with the Secretary of the Office of Policy and Management, at the price that would be paid under the ConnPACE program. Payment shall be made under the ConnPACE program for prescription drugs that are not Medicare Part D drugs, as defined in said act.]

[(3)] (2) Payment for a replacement prescription under the program shall be made only if the eligible person signs a statement, on such form as the commissioner prescribes and subject to penalty under section 17b-497, that the prescription drug is lost or was stolen or

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destroyed and the person has made a good faith effort to recover the prescription drug, except that payment for a replacement prescription shall not be made on behalf of a person more than twice in a calendar year.

(c) Any eligible resident who (1) is insured under a policy, [including an endorsed Medicare prescription drug discount card, which provides full or partial coverage for prescription drugs,] and (2) expects to exhaust such coverage, may apply to participate in the program prior to the exhaustion of such coverage. Such application shall be valid for the applicable income year. To be included in the program, on or after the date the applicant exhausts such coverage, the applicant or the applicant's designee shall notify the department that such coverage is exhausted and, if required by the department, shall submit evidence of exhaustion of coverage. Not later than ten days after an eligible resident submits such evidence, such resident shall be included in the program. The program shall [, except for those beneficiaries with an endorsed Medicare prescription drug discount card,] (A) cover prescriptions that are not covered by any other plan of insurance or assistance available to the eligible resident and that meet the requirements of this chapter, and (B) retroactively cover such prescriptions filled after or concurrently with the exhaustion of such coverage. Nothing in this subsection shall be construed to prevent a resident from applying to participate in the program as otherwise permitted by this chapter and regulations adopted pursuant to this chapter.

[(d) (1) As a condition of eligibility for participation in the ConnPACE program, a resident with an income at or below one hundred thirty-five per cent of the federal poverty level, who is Medicare Part A or Part B eligible, shall obtain annually an endorsed Medicare prescription drug discount card designated by the Commissioner of Social Services for use in conjunction with the

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ConnPACE program. The commissioner shall be the authorized representative of such resident for the purpose of enrolling a resident in the transitional assistance program of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. As the authorized representative for this purpose, the commissioner may sign required forms and enroll such resident in an endorsed Medicare prescription drug discount card on the resident's behalf. Such resident shall have the opportunity to select an endorsed Medicare prescription drug discount card designated by the commissioner for use in conjunction with the ConnPACE program, and shall be notified of such opportunity by the commissioner. In the event that such resident does not select an endorsed Medicare prescription drug discount card designated by the commissioner for use in conjunction with the ConnPACE program within a reasonable period of time, as determined by the commissioner, the department shall enroll the resident in an endorsed Medicare prescription drug discount card designated by the commissioner. The provisions of this subdivision shall remain in effect until the effective date of the Medicare Part D program pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(2) The commissioner may require, as a condition of eligibility for participation in the ConnPACE program, that a resident with an income above one hundred thirty-five per cent of the federal poverty level, who is Medicare Part A or Part B eligible, obtain an endorsed Medicare prescription drug discount card designated by the commissioner for use in conjunction with the ConnPACE program if obtaining such discount card is determined by the commissioner to be cost-effective to the state. In such an event, the commissioner may provide payment for any Medicare prescription drug discount card enrollment fees. The provisions of this subdivision shall remain in effect until the effective date of the Medicare Part D program pursuant

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to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(e) On and after the effective date of the Medicare Part D program pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, enrollment in the Medicare Part D program, for individuals eligible for such program in accordance with said act, shall be a condition of eligibility for the ConnPACE program. The ConnPACE program shall cover the financial costs of Medicare Part D participation for ConnPACE recipients enrolled in Medicare Part D in accordance with subsection (b) of this section. Effective July 1, 2005, a ConnPACE recipient shall, as a condition of eligibility, provide information regarding the recipient's assets and income, as defined by said act, and that of the recipient's spouse, provided said spouse resides in the same household, as required by the Department of Social Services in order to determine the extent of benefits for which the recipient is eligible under Medicare Part D.

(f) Each ConnPACE applicant or recipient who is eligible for Medicare Part D shall enroll in a Medicare Part D benchmark plan. The Commissioner of Social Services may be the authorized representative of a ConnPACE applicant or recipient for purposes of: (1) Enrolling in a Medicare Part D benchmark plan, (2) submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or (3) facilitating the enrollment in a Medicare savings program of any such applicant or recipient who elects to participate in such program. The applicant or recipient shall have the opportunity to select a Medicare Part D benchmark plan and shall be notified of such opportunity by the commissioner. The applicant or recipient, prior to selecting a Medicare Part D benchmark plan, shall have the opportunity to consult with the

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commissioner, or the commissioner's designated agent, concerning the selection of a Medicare Part D benchmark plan that best meets the prescription drug needs of such applicant or recipient. In the event that such applicant or recipient does not select a Medicare Part D benchmark plan within a reasonable period of time, as determined by the commissioner, the commissioner shall enroll the applicant or recipient in a Medicare Part D benchmark plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner as such applicant's or recipient's representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner.]

[(g)] (d) The Commissioner of Social Services may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of subsection (c) of this section. Such regulations may provide for the electronic transmission of relevant coverage information between a pharmacist and the department or between an insurer and the department in order to expedite applications and notice. The commissioner may implement the policies and procedures necessary to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

Sec. 90. Section 17b-265f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

No pharmacy shall claim payment from the Department of Social Services under a medical assistance program administered by the department [or the Medicare Part D Supplemental Needs Fund, established pursuant to section 17b-265e,] for prescription drugs

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dispensed to individuals who have other prescription drug insurance coverage unless such coverage has been exhausted and the individual is otherwise eligible for such a medical assistance program. [or assistance from the Medicare Part D Supplemental Needs Fund.] The department shall recoup from the submitting pharmacy any claims submitted to and paid by the department when other insurance coverage is available. The department shall investigate a pharmacy that consistently submits ineligible claims for payment to determine whether the pharmacy is in violation of its medical assistance provider agreement or is committing fraud or abuse in the program and based on the findings of such investigation, may take action against such pharmacy, in accordance with state and federal law.

Sec. 91. Section 17b-256f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Beginning October 1, 2009, and annually thereafter, the Commissioner of Social Services shall increase income disregards used to determine eligibility by the Department of Social Services for the federal Specified Low-Income Medicare Beneficiary, the Qualified Medicare Beneficiary and the Qualifying Individual Programs, administered in accordance with the provisions of 42 USC 1396d(p), by an amount that equalizes the income levels and deductions used to determine eligibility for said programs with income levels and deductions used to determine eligibility for the ConnPACE program under subsection (a) of section 17b-492, as amended by this act. The commissioner shall not apply an asset test for eligibility under the Medicare Savings Program. The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of the intent to adopt the regulations in the Connecticut Law Journal not later than twenty days after the date

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of implementation. Such policies and procedures shall be valid until the time final regulations are adopted.

Sec. 92. (NEW) (*Effective July 1, 2011*) The Commissioner of Social Services may establish a fee schedule for the payment of any outpatient hospital services under the Medicaid program.

Sec. 93. Section 17b-260d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

[(a)] The Commissioner of Social Services shall apply for a home and community-based services waiver pursuant to Section 1915(c) of the Social Security Act that will allow the commissioner to develop and implement a program for the provision of home or community-based services, as defined in 42 CFR 440.180, to not more than [one hundred] fifty persons currently receiving services under the Medicaid program who (1) have tested positive for human immunodeficiency virus or have acquired immune deficiency syndrome, and (2) would remain eligible for Medicaid if admitted to a hospital, nursing facility or intermediate care facility for the mentally retarded, or in the absence of the services that are requested under such waiver, would require the Medicaid covered level of care provided in such facilities. [In accordance with 42 CFR 440.180, such persons shall be eligible to receive services that are deemed necessary by the commissioner to meet their unique needs in order to avoid institutionalization.]

[(b)] If the commissioner fails to submit the application for the waiver to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations by February 1, 2010, the commissioner shall submit a written report to said committees not later than February 2, 2010. The report shall include, but not be limited to: (1) An explanation of the reasons for failing to seek the waiver; and (2) an estimate of the fiscal impact that would result from the approval of the waiver in one

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calendar year.]

Sec. 94. Subsection (a) of section 17b-278g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) To the extent permitted by federal law, no payment shall be provided by the Department of Social Services under the Medicaid program for more than one pair of eyeglasses [per year] every two years. Said department shall administer the payment for eyeglasses and contact lenses as cost effectively as possible.

Sec. 95. Section 17b-372 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) As used in this section, "small house nursing home" means an alternative nursing home facility that (1) consists of one or more units that are designed and modeled as a private home, (2) houses no more than [ten] fourteen individuals in each unit, (3) includes private rooms and bathrooms, (4) provides for an increased role for support staff in the care of residents, (5) incorporates a philosophy of individualized care, and (6) is licensed as a nursing home under chapter 368v.

(b) The Commissioner of Social Services [shall] may establish, within available appropriations, a pilot program to support the development of [up to ten] one small house nursing [homes] home in the state in order to improve the quality of life for nursing home residents and to support a goal of providing nursing home care in a more home-like and less institution-like setting. The total number of beds under such project shall not exceed two hundred eighty beds.

[(c) Any existing chronic and convalescent nursing home or rest home with nursing supervision may apply to the commissioner for approval of a proposal to develop a small house nursing home and to relocate Medicaid certified beds from its facility to such small house

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nursing home. The commissioner shall require each small house nursing home under the pilot program to seek certification to participate in the Title XVIII and Title XIX programs and may establish additional requirements for such small house nursing homes. Not later than October 1, 2008, the commissioner shall develop guidelines relating to the design specifications and requirements for small house nursing homes for purposes of the pilot program, and shall submit a copy of the guidelines to the joint standing committee of the General Assembly having cognizance of matters relating to human services. Not later than thirty days after receipt of such guidelines, said joint standing committee may advise the commissioner of its approval, denial or modifications, if any, of such guidelines. If said joint standing committee does not act during such thirty-day period, such guidelines shall be deemed approved. If approved, the commissioner shall make such guidelines available to applicants. Each chronic and convalescent nursing home or rest home with nursing supervision submitting a proposal shall provide: (1) A description of the proposed project; (2) information concerning the financial and technical capacity of the applicant to undertake the proposed project; (3) a project budget; (4) information that the relocation of beds shall result in a reduction in the number of nursing facility beds in the state; and (5) any additional information the commissioner deems necessary.

(d) The commissioner, in consultation with the Long-Term Care Planning Committee, established pursuant to section 17b-337, shall evaluate proposals received pursuant to subsection (c) of this section and may approve, after consultation with and approval of the Secretary of the Office of Policy and Management, up to ten proposals. The commissioner shall give preference to proposals that include the use of fuel cells or other energy technologies that promote energy efficiency in such small house nursing home. The commissioner may give preference to proposals to develop a small house nursing home in a distressed municipality, as defined in section 32-9p, with a

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population greater than one hundred thousand persons.

(e) Notwithstanding the provisions of subsection (d) of this section, the commissioner shall approve no more than one project through June 30, 2011. The total number of beds under such project shall not exceed two hundred eighty beds.]

[(f)] (c) A small house nursing home developed under this section shall comply with the provisions of sections 17b-352 to 17b-354, inclusive.

Sec. 96. Section 17b-802 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Commissioner of Social Services shall establish, within available appropriations, and administer a security deposit guarantee program for persons who (1) (A) are recipients of temporary family assistance, aid under the state supplement program, or state-administered general assistance, or (B) have a documented showing of financial need, and (2) (A) are residing in emergency shelters or other emergency housing, cannot remain in permanent housing due to any reason specified in subsection (a) of section 17b-808, or are served a [notice to quit] writ, summons and complaint in a summary process action instituted pursuant to chapter 832, or (B) have a rental assistance program or federal Section 8 certificate or voucher. Under such program, the Commissioner of Social Services may provide security deposit guarantees for use by such persons in lieu of a security deposit on a rental dwelling unit. Eligible persons may receive a security deposit guarantee in an amount not to exceed the equivalent of two months' rent on such rental unit. No person may apply for and receive a security deposit guarantee more than once in any eighteen-month period without the express authorization of the Commissioner of Social Services, except as provided in subsection (b) of this section. The Commissioner of Social Services may deny eligibility for the security

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deposit guarantee program to an applicant for whom the commissioner has paid two [or more] claims by landlords. [during the immediately preceding five-year period.] The Commissioner of Social Services may establish priorities for providing security deposit guarantees to eligible persons described in subparagraphs (A) and (B) of subdivision (2) of this subsection in order to administer the program within available appropriations.

(b) In the case of any person who qualifies for a guarantee, the Commissioner of Social Services, or any emergency shelter under contract with the Department of Social Services to assist in the administration of the security deposit guarantee program established pursuant to subsection (a) of this section, may execute a written agreement to pay the landlord for any damages suffered by the landlord due to the tenant's failure to comply with such tenant's obligations as defined in section 47a-21, provided the amount of any such payment shall not exceed the amount of the requested security deposit. Notwithstanding the provisions of subsection (a) of this section, if a person who has previously received a grant for a security deposit or a security deposit guarantee becomes eligible for a subsequent security deposit guarantee within eighteen months after a claim has been paid on a prior security deposit guarantee, such person may receive a security deposit guarantee. The amount of the subsequent security deposit guarantee for which such person would otherwise have been eligible shall be reduced by (1) any amount of a previous grant which has not been returned to the department pursuant to section 47a-21, or (2) the amount of any payment made to the landlord for damages pursuant to this subsection.

(c) Any payment made pursuant to this section to any person receiving temporary family assistance, aid under the state supplement program or state-administered general assistance shall not be deducted from the amount of assistance to which the recipient would otherwise

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be entitled.

(d) On and after July 1, 2000, no special need or special benefit payments shall be made by the commissioner for security deposits from the temporary family assistance, state supplement, or state-administered general assistance programs.

(e) The Commissioner of Social Services may, within available appropriations, on a case-by-case basis, provide a security deposit grant to a person eligible for the security deposit guarantee program established under subsection (a) of this section, in an amount not to exceed the equivalent of one month's rent on such rental unit provided the commissioner determines that emergency circumstances exist which threaten the health, safety or welfare of a child who resides with such person. Such person shall not be eligible for more than one such grant without the authorization of said commissioner. Nothing in this section shall preclude the approval of such one-month security deposit grant in conjunction with a one-month security deposit guarantee.

(f) The Commissioner of Social Services may provide a security deposit grant to a person receiving such grant through any emergency shelter under an existing contract with the Department of Social Services to assist in the administration of the security deposit program, but in no event shall a payment be authorized after October 1, 2000. Nothing in this section shall preclude the commissioner from entering into a contract with one or more emergency shelters for the purpose of issuing security deposit guarantees.

(g) A landlord may submit a claim for damages not later than forty-five days after the date of termination of the tenancy. Payment shall be made only for a claim that includes receipts for repairs made. No claim shall be paid for an apartment from which a tenant vacated because substandard conditions made the apartment uninhabitable, as determined by a local, state or federal regulatory agency.

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(h) Any person with income exceeding one hundred fifty per cent of the federal poverty level, who is found eligible to receive a security deposit guarantee under this section and for whom the commissioner has paid a claim by a landlord, shall contribute five per cent of one month's rent to the payment of the security deposit. The commissioner may waive such payment for good cause.

[(g)] (i) The Commissioner of Social Services shall adopt regulations, in accordance with the provisions of chapter 54, to administer the program established pursuant to this section and to set eligibility criteria for the program, but may implement the program [until June 30, 2003,] while in the process of adopting such regulations provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days after implementation.

Sec. 97. Section 17b-749a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [Commissioner of Social Services, in consultation with the] Commissioner of Education [.] shall establish, within available appropriations, a program to (1) purchase directly or provide subsidies to parents to purchase child day care services provided by any elementary or secondary school, nursery school, preschool, day care center, group day care home, family day care home, family resource center, Head Start program, or local or regional board of education, provided, if the commissioner purchases such services directly, he shall give preference to purchasing from providers of full-day and year-round programs; and (2) award grants to providers of school readiness programs, as defined in section 10-16p, to increase the hours of operation of their programs in order to provide child care for children attending such programs. The commissioner, for purposes of subdivision (1) of this subsection, [shall] may model the program on the program established pursuant to section 17b-749.

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(b) No funds received by a provider pursuant to this section shall be used to supplant federal funding received for early childhood education on behalf of children in an early childhood education program.

(c) The [Commissioners of Social Services and] Commissioner of Education shall: (1) Coordinate the development of a range of alternative programs to meet the needs of all children; (2) foster partnerships between school districts and private organizations; (3) provide information and assistance to parents in selecting an appropriate school readiness program; and (4) work to ensure, to the extent possible, that school readiness programs allow open enrollment for all children and allow families receiving benefits for such a program to choose a public or accredited private program.

Sec. 98. Section 17b-749g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) There is established a child care facilities loan guarantee program for the purpose of guaranteeing loans for the expansion or development of child care and child development centers in the state. The program shall contain any moneys required by law to be deposited in the program, including, but not limited to, any moneys appropriated by the state, premiums and fees for guaranteeing loans, and proceeds from the sale, disposition, lease or rental of collateral relating to loan guarantees. Any balance remaining in the program at the end of any fiscal year shall be carried forward in the program for the fiscal year next succeeding. The program shall be used to guarantee loans pursuant to subsection (b) of this section and to pay reasonable and necessary expenses incurred for administration under this section. The Commissioner of [Social Services] Education may enter into a contract with a quasi-public agency, banking institution or nonprofit corporation to provide for the administration of the program, provided no loan guarantee shall be made from the program without the

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authorization of the commissioner as provided in subsection (b) of this section. The total aggregate amount of guarantees from the program, with respect to the insured portions of the loan, may not exceed at any one time an amount equal to three times the balance in the guarantee program.

(b) The state, acting by and in the discretion of the Commissioner of [Social Services] Education, may guarantee the repayment of loans, including, but not limited to, principal and interest, to a lending institution that has provided funding for the construction, reconstruction, rehabilitation or improvement of child care and child development facilities. The total aggregate of any loan guarantee under this section shall be not less than twenty per cent and shall not exceed fifty per cent of the principal amount of the obligation, as determined by approved underwriting standards approved by the commissioner, and upon such terms and conditions as the commissioner may prescribe. The term of any loan guarantee shall be determined by the useful life of the improvement but in no event shall exceed thirty years. The commissioner shall arrange by contract with each lending institution or the borrower to safeguard the interests of the program in the event of a default by the borrower, including, at the discretion of the commissioner, provision for notice to the program of default by the borrower, for foreclosure or other realization upon any security for the loan, for the time and conditions for payment to the lending institution by the program of the amount of any loss to the lending institution guaranteed by the program and for the disposition of the proceeds realized from any security for the loan guaranteed. When it appears desirable for a temporary period upon default or threatened default by the borrower, the commissioner may authorize payments of installments of principal or interest, or both, from the program to the lending institution, and of taxes and insurance, which payments shall be repaid under such conditions as the program may prescribe and the program may also agree to revise terms of financing

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when such appears pertinent. Upon request of the lending institution, the commissioner may at any time, under such equitable terms and conditions as it may prescribe, consent to the release of the borrower from his liability under the loan or consent to the release of parts of any secured property from the lien of the lending institution.

(c) Priority for loan guarantees shall be given to financing child care centers and child development centers that (1) have obtained accreditation from the National Association for the Education of Young Children or have an application pending for such accreditation, and (2) are included in a local school readiness plan, and (3) shall promote the colocation of programs endorsed by the Commissioners of Education and Social Services pursuant to section 4b-31. School readiness programs, licensed child care providers or nonprofit developers of a child care center operating under a legally enforceable agreement with child care providers are eligible for such guaranteed loans.

(d) The Commissioner of [Social Services] Education may adopt regulations, in accordance with the provisions of chapter 54, to establish procedures and qualifications for application for guarantees under this section.

Sec. 99. Section 17b-749h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) There is established a program to be known as the "child care facilities direct revolving loan program". The program shall contain any moneys required by law to be deposited in the program, including, but not limited to, any moneys appropriated by the state, premiums, fees, interest payments and principal payments on direct loans and proceeds from the sale, disposition, lease or rental of collateral relating to direct loans. Any balance remaining in the program at the end of any fiscal year shall be carried forward in the

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program for the next succeeding fiscal year. The program shall be used to make loans pursuant to subsection (b) of this section, to make loan guarantees and to pay reasonable and necessary expenses incurred in administering loans and loan guarantees under this section. The Commissioner of [Social Services] Education may enter into a contract with a quasi-public agency, banking institution or nonprofit corporation to provide for the administration of the loan program, provided no loan or loan guarantee shall be made from the fund without the authorization of the commissioner as provided in subsection (b) of this section.

(b) The state, acting by and in the discretion of the Commissioner of [Social Services] Education, may enter into a contract to provide financial assistance in the form of interest-free loans, deferred loans or guaranteed loans to child care providers or to nonprofit developers of a child care facility operating under a legally enforceable agreement with a child care provider, for costs or expenses incurred and directly connected with the expansion, improvement or development of child care facilities. Such costs and expenses may include: (1) Advances of loan proceeds for direct loans; (2) expenses incurred in project planning and design, including architectural expenses; (3) legal and financial expenses; (4) expenses incurred in obtaining required permits and approvals; (5) options to purchase land; (6) expenses incurred in obtaining required insurance; (7) expenses incurred in meeting state and local child care standards; (8) minor renovations and upgrading child care facilities to meet such standards and loans for the purpose of obtaining licensure under section 19a-77; (9) purchase and installation of equipment, machinery and furniture, including equipment needed to accommodate children with special needs; and (10) other preliminary expenses authorized by the commissioner. Loan proceeds shall not be used for the refinancing of existing loans, working capital, supplies or inventory.

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(c) The amount of a direct loan under this section may be up to eighty per cent of the total amount of investment but shall not exceed twenty-five thousand dollars for such facility as determined by the commissioner except that if an applicant for a loan under this section has an existing loan that is guaranteed by the child care facilities loan guarantee program, established under section 17b-749g, as amended by this act, the direct loan provided under this section shall not exceed twenty per cent of the investment. The amount of any guarantee and a direct loan under this section shall not exceed eighty per cent.

(d) Each provider applying for a loan under this section shall submit an application, on a form provided by the commissioner that shall include, but is not limited to, the following information: (1) A detailed description of the proposed or existing child care facility; (2) an itemization of known and estimated costs; (3) the total amount of investment required to expand or develop the child care facility; (4) the funds available to the applicant without financial assistance from the department; (5) the amount of financial assistance sought from the department; (6) information relating to the financial status of the applicant, including, if available, a current balance sheet, a profit and loss statement and credit references; and (7) evidence that the loan applicant shall, as of the loan closing, own, have an option to purchase or have a lease for the term of the loan. Security for the loan may include an assignment of the lease or other subordination of any mortgage and the borrower shall be in default if the loan is not used for the intended purpose.

(e) Payments of principal and interest on such loans shall be paid to the State Treasurer for deposit in the child care facilities direct revolving loan program established in subsection (a) of this section.

(f) The Commissioner of [Social Services] Education may adopt regulations, in accordance with chapter 54, to carry out the provisions of this section. Such regulations may clarify loan procedures,

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repayment terms, security requirements, default and remedy provisions, and such other terms and conditions as said commissioner shall deem appropriate.

Sec. 100. Section 17b-749i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Within appropriations available to the State Treasurer for child care facilities, not already allocated toward debt service for specific child care facilities, the Commissioner of [Social Services] Education may, upon submission of a request by a facility operating a child care program that is financed with tax-exempt or taxable bonds issued through the Connecticut Health and Educational Facilities Authority, allow actual debt service, comprised of principal, interest and premium, if any, on the loan or loans, a debt service reserve fund and a reasonable repair and replacement reserve to be paid, provided such debt service terms and amounts are determined by the commissioner, at the time the loan is entered into, to be reasonable in relation to the useful life and base value of the property.

Sec. 101. Subsection (a) of section 17b-749c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The [Commissioner of Social Services, in consultation with the] Commissioner of Education [.] shall establish a program, within available appropriations, to provide, on a competitive basis, supplemental quality enhancement grants to providers of child day care services or providers of school readiness programs pursuant to section 10-16p and section 10-16u. Child day care providers and school readiness programs may apply for a supplemental quality enhancement grant at such time and on such form as the Commissioner of [Social Services] Education prescribes. Effective July 1, 2011, the commissioner shall make funds payable to providers under

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such grants on a prospective basis.

Sec. 102. Section 12-263a of the general statutes, as amended by section 145 of public act 11-6, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011, and applicable to calendar quarters commencing on or after July 1, 2011*):

As used in sections 12-263a to 12-263e, inclusive, as amended by [this act] public act 11-6:

(1) "Hospital" means any health care facility or institution, as defined in section 19a-630, which is licensed as a short-term general hospital by the Department of Public Health but does not include (A) any hospital which, on October 1, 1997, is within the class of hospitals licensed by the department as children's general hospitals, or (B) a short-term acute hospital operated exclusively by the state other than a short-term acute hospital operated by the state as a receiver pursuant to chapter 920;

(2) "Net patient revenue" means the amount of [a hospital's gross revenue, including the amount received by the hospital from the federal government for Medicare patients] accrued payments earned by a hospital for the provision of inpatient and outpatient services;

(3) "Commissioner" means the Commissioner of Revenue Services;

(4) "Department" means the Department of Revenue Services.

Sec. 103. Section 12-263b of the general statutes, as amended by section 146 of public act 11-6, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011, and applicable to calendar quarters commencing on or after July 1, 2011*):

(a) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a tax on the net patient revenue of each

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hospital in this state to be paid each calendar quarter [at the rate of four and six-tenths per cent] The rate of such tax shall be up to the maximum rate allowed under federal law. The Commissioner of Social Services shall determine the base year on which such tax shall be assessed. The Commissioner of Social Services may, in consultation with the Secretary of the Office of Policy and Management and in accordance with federal law, exempt a hospital from the tax on payment earned for the provision of outpatient services based on financial hardship.

(b) Each hospital shall, on or before the last day of January, April, July and October of each year, render to the Commissioner of Revenue Services a return, on forms prescribed or furnished by the Commissioner of Revenue Services and signed by one of its principal officers, stating specifically the name and location of such hospital, and the amount of its net patient revenue for the calendar quarter ending the last day of the preceding month. Payment shall be made with such return. Each hospital shall file such return electronically with the department and make such payment by electronic funds transfer in the manner provided by chapter 228g, irrespective of whether the hospital would otherwise have been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of chapter 228g.

Sec. 104. Section 17b-261a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any transfer or assignment of assets resulting in the imposition of a penalty period shall be presumed to be made with the intent, on the part of the transferor or the transferee, to enable the transferor to obtain or maintain eligibility for medical assistance. This presumption may be rebutted only by clear and convincing evidence that the transferor's eligibility or potential eligibility for medical assistance was not a basis for the transfer or assignment.

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(b) Any transfer or assignment of assets resulting in the establishment or imposition of a penalty period shall create a debt, as defined in section 36a-645, that shall be due and owing by the transferor or transferee to the Department of Social Services in an amount equal to the amount of the medical assistance provided to or on behalf of the transferor on or after the date of the transfer of assets, but said amount shall not exceed the fair market value of the assets at the time of transfer. The Commissioner of Social Services, the Commissioner of Administrative Services and the Attorney General shall have the power or authority to seek administrative, legal or equitable relief as provided by other statutes or by common law.

(c) The Commissioner of Social Services may waive the imposition of a penalty period when the transferor (1) in accordance with the provisions of section 3025.25 of the department's Uniform Policy Manual, suffers from dementia at the time of application for medical assistance and cannot explain transfers that would otherwise result in the imposition of a penalty period; or (2) suffered from dementia at the time of the transfer; or (3) was exploited into making such a transfer due to dementia. Waiver of the imposition of a penalty period does not prohibit the establishment of a debt in accordance with subsection (b) of this section.

(d) An institutionalized individual shall not be penalized for the transfer of an asset if the entire amount of the transferred asset is returned to the institutionalized individual. The partial return of a transferred asset shall not result in a reduced penalty period.

(1) If there are multiple transfers of assets to the same or different transferees, a return of anything less than the total amount of the transferred assets from all of the separate transferees shall not constitute a return of the entire amount of the transferred assets.

(2) If the circumstances surrounding the transfer of an asset and

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return of the entire amount of the asset to the institutionalized individual indicates to the Department of Social Services that such individual, such individual's spouse or such individual's authorized representative intended, from the time the asset was transferred, that the transferee would subsequently return the asset to such individual, such individual's spouse or such individual's authorized representative for the purpose of altering the start of the penalty period or shifting nursing facility costs, that may have been borne by such individual, to the Medicaid program, the entire amount of the returned asset shall be considered available to such individual from the date of transfer. If such individual demonstrates to the department that the purpose of the transfer and its subsequent return was not to alter the penalty period or qualify such individual for Medicaid eligibility, the entire amount of the returned asset is considered available to the individual from the date of the return of the transferred asset.

(3) The conveyance and subsequent return of an asset for the purpose of shifting costs to the Medicaid program shall be regarded as a trust-like device. Such asset shall be considered available for the purpose of determining Medicaid eligibility.

(4) For purposes of this section, an "institutionalized individual" means an individual who is receiving (A) services from a long-term care facility, (B) services from a medical institution which are equivalent to those services provided in a long-term care facility, or (C) home and community-based services under a Medicaid waiver.

~~[(d)]~~ (e) The Commissioner of Social Services, pursuant to section 17b-10, shall implement the policies and procedures necessary to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures

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shall be valid until the time final regulations are effective.

Sec. 105. Section 17b-28d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services, in consultation with the Commissioner of Education, shall submit to the Centers for Medicare and Medicaid Services an amendment to the state Medicaid plan [required by Title XIX of the Social Security Act to enhance federal financial participation for Medicaid] concerning school-based child health services provided to Medicaid enrolled children requiring special education pursuant to an individualized education plan. [The amendment shall propose (1) the establishment of either a simplified cost-based or fixed fee method of determining state expenditures for eligible Medicaid services provided to such children, and (2) the replacement of the annual activity cost reports for all school-based child health services provided to such children. Any fixed fee established by the Department of Social Services shall be a per diem or monthly rate per child and shall reflect reimbursable administrative expenses.] Such amendment to the Medicaid plan shall maintain and enhance, to the extent permitted, federal financial participation associated with such costs through a service-specific rate method.

(b) The Commissioner of Social Services shall provide written notification to each local or regional board of education in the state of any change in policy or billing procedure not later than thirty days after the effective date of such change.

Sec. 106. Section 17b-278a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

The Commissioner of Social Services shall amend the Medicaid state plan to provide coverage for treatment for smoking cessation. [ordered by a licensed health care professional who possesses valid and current

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state licensure to prescribe such drugs in accordance with a plan developed by the commissioner to provide smoking cessation services. The commissioner shall present such plan to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations by January 1, 2003, and, if such plan is approved by said committees and funding is provided in the budget for the fiscal year ending June 30, 2004, such plan shall be implemented on July 1, 2003. If the initial treatment provided to the patient for smoking cessation, as allowed by the plan, is not successful as determined by a licensed health care professional, all prescriptive options for smoking cessation shall be available to the patient.] Notwithstanding the provisions of section 17b-280a, as amended by this act, such treatment may include coverage for prescription drugs, including over-the-counter drugs and counseling.

Sec. 107. Section 17b-280a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Notwithstanding any provision of the general statutes, no payment shall be made under a medical assistance program administered by the Department of Social Services, except for the medical assistance program established pursuant to section 17b-256, for an over-the-counter drug, except for (1) insulin [,] and insulin syringes, [and] (2) nutritional supplements for individuals who are required to be tube fed or who cannot safely ingest nutrition in any other form, and as may be required by federal law, and (3) effective January 1, 2012, smoking cessation drugs as provided in section 17b-278a, as amended by this act. On or before August 1, 2011, the Commissioner of Social Services shall provide notice to pharmacists who provide services to beneficiaries of a medical assistance program administered by the department that such pharmacists may bill the department for supplies utilized in the treatment of diabetes using the durable medical equipment, medical surgical supply fee schedule. The commissioner

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shall provide a copy of such notice to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

Sec. 108. Section 17b-85 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

If any person receiving an award for the care of any dependent child or children, or any person legally liable for the support of such child or children, or any other person being supported wholly or in part under the provisions of the state supplement program, medical assistance program, temporary family assistance program [,] or state-administered general assistance program [or supplemental nutrition assistance program] or any beneficiary under [said sections] such provisions or any legally liable relative of such beneficiary, receives property, wages, income or resources of any kind, such person or beneficiary, within ten days after obtaining knowledge of or receiving such property, wages, income or resources, shall notify the commissioner thereof, orally or in writing, unless good cause is established for failure to provide such notice, as determined by the commissioner. No such person or beneficiary shall sell, assign, transfer, encumber or otherwise dispose of any property without the consent of the commissioner. The provisions of section 17b-137 shall be applicable with respect to any person applying for or receiving an award under [said sections. Any] such provisions. Except for the supplemental nutrition assistance program, any change in the information which has been furnished on an application form or a redetermination of eligibility form shall also be reported to the commissioner, orally or in writing, within ten days of the occurrence of such change, unless good cause is established for failure to provide such notice, as determined by the commissioner. For participants in the supplemental nutrition assistance program, the commissioner shall establish reporting requirements regarding such changes in

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information in accordance with applicable federal law, as may be amended from time to time.

Sec. 109. Subdivision (2) of subsection (a) of section 17b-295 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) [The] In accordance with federal law, the commissioner may impose a premium requirement on families whose income exceeds two hundred thirty-five per cent of the federal poverty level as a component of the family's cost-sharing responsibility [, provided: (A) The family's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement, and (B) premium requirements shall not exceed the sum of thirty-eight dollars per month for families with one child, with a maximum premium of sixty dollars per month per family. The commissioner shall not impose a premium requirement on families whose income exceeds one hundred eighty-five per cent of the federal poverty level but does not exceed two hundred thirty-five per cent of the federal poverty level] and, for the fiscal years ending June 30, 2012, to June 30, 2016, inclusive, may annually increase the premium requirement based on the percentage increase in the Consumer Price Index for medical care services; and

Sec. 110. (NEW) (*Effective from passage*) (a) The Commissioner of Social Services may establish medical homes as a model for delivering care to recipients of assistance under medical assistance programs administered by the Department of Social Services.

(b) The commissioner may implement policies and procedures necessary to (1) establish medical homes as provided for in subsection (a) of this section, and (2) pursue optional initiatives authorized pursuant to the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010,

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relating to: (A) Coverage of family planning services; (B) the establishment of a temporary high risk pool for individuals with preexisting conditions; (C) the establishment of an incentive program for the prevention of chronic diseases; (D) the provision of health homes to medical assistance beneficiaries with chronic conditions; (E) the establishment of Medicaid payments to institutions for mental disease demonstration project; (F) the establishment of a dual eligible demonstration program; (G) the establishment of a balancing incentive payment program for home and community-based services; (H) the establishment of a "Community First Choice Option"; (I) the establishment of a demonstration project to make bundled payments to hospitals; and (J) the establishment of a demonstration project to allow pediatric medical providers to organize as accountable care organizations while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of the intention to adopt the regulations in the Connecticut Law Journal not later than twenty days after the date of implementation of such policies and procedures. Such policies and procedures shall remain valid for three years following the date of publication in the Connecticut Law Journal unless otherwise provided for by the General Assembly. Notwithstanding the time frames established in subsection (c) of section 17b-10 of the general statutes, the commissioner shall submit such policies and procedures in proposed regulation form to the legislative regulation review committee not later than three years following the date of publication of its intent to adopt regulations as provided for in this subsection. In the event that the commissioner is unable to submit proposed regulations prior to the expiration of the three-year time period as provided for in this subsection, the commissioner shall submit written notice, not later than thirty-five days prior to the date of expiration of such time period, to the legislative regulation review committee and the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state

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agencies indicating that the department will not be able to submit the proposed regulations on or before such date and shall include in such notice (i) the reasons why the department will not submit the proposed regulations by such date, and (ii) the date by which the department will submit the proposed regulations. The legislative regulation review committee may require the department to appear before the committee at a time prescribed by the committee to further explain such reasons and to respond to any questions by the committee about the policy. The legislative regulation review committee may request the joint standing committee of the General Assembly having cognizance of matters relating to human services to review the department's policy, the department's reasons for not submitting the proposed regulations by the date specified in this section and the date by which the department will submit the proposed regulations. Said joint standing committee may review the policy, such reasons and such date, may schedule a hearing thereon and may make a recommendation to the legislative regulation review committee.

Sec. 111. (NEW) (*Effective July 1, 2011*) (a) Notwithstanding any provision of the general statutes, on and after July 1, 2011, the Department of Social Services may, within available appropriations, make interim monthly medical assistance disproportionate share payments to short-term general hospitals. The total amount of interim payments made to such hospitals individually and in the aggregate shall maximize federal matching payments under the medical assistance program as determined by the Department of Social Services, in consultation with the Office of Policy and Management. No payments shall be made under this section to (1) any hospital which, on July 1, 2011, is within the class of hospitals licensed by the Department of Public Health as a children's general hospital, or (2) a short-term acute hospital operated exclusively by the state other than a short-term acute hospital operated by the state as a receiver pursuant

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to chapter 920 of the general statutes. The monthly interim payment amount for each hospital shall be determined by the Commissioner of Social Services based upon the information submitted by the hospital pursuant to Section 1001(d) of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(b) Effective July 1, 2011, interim payments made to hospitals pursuant to this section for the succeeding fifteen months shall be based on 2009 federal fiscal year data and may be adjusted at the commissioner's discretion for accuracy. Effective October 1, 2012, interim payments shall be based on the most recent federal fiscal year data available. For federal fiscal year 2011 and succeeding federal fiscal years, final disproportionate share payment amounts shall be recalculated and reallocated in accordance with Section 1001(d) of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The commissioner shall prescribe uniform annual hospital data reporting forms. Payments made pursuant to this section shall be in addition to inpatient hospital rates determined pursuant to section 17b-239 of the general statutes, as amended by this act. The commissioner may withhold payment to a hospital to offset money owed by the hospital to the state.

Sec. 112. (NEW) (*Effective July 1, 2011*) (a) On or before January 1, 2012, the Commissioner of Social Services, in consultation with the Commissioners of Public Health and Mental Health and Addiction Services and the Secretary of the Office of Policy and Management, shall submit to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies a plan concerning the implementation of a cost neutral acuity-based method for establishing rates to be paid to hospitals that is phased in over a period of time.

(b) The commissioner may establish a blended in-patient hospital case rate that includes services provided to all Medicaid recipients and

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may exclude certain diagnoses as determined by the commissioner if the establishment of such rates is needed to ensure that the conversion to an administrative services organization is cost neutral to hospitals in the aggregate and ensures patient access.

Sec. 113. Subsection (d) of section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(d) The state shall also pay to such hospitals for each outpatient clinic and emergency room visit a reasonable rate to be established annually by the commissioner for each hospital, such rate to be determined by the reasonable cost of such services. The emergency room visit rates in effect June 30, 1991, shall remain in effect through June 30, 1993, except those which would have been decreased effective July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained herein shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios in effect June 30, 1991, shall be reduced effective July 1, 1991, by the most recent annual increase in the consumer price index for medical care. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios computed to be effective July 1, 1994, shall be reduced by the most recent annual increase in the consumer price index for medical care. The emergency room visit rates in effect June 30, 1994, shall remain in effect through December 31, 1994. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995, and may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to hospitals in the aggregate and ensures patient access. Except with respect to the rate periods beginning July 1,

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1999, and July 1, 2000, such fee schedule shall be adjusted annually beginning July 1, 1996, to reflect necessary increases in the cost of services. Notwithstanding the provisions of this subsection, the fee schedule for the rate period beginning July 1, 2000, shall be increased by ten and one-half per cent, effective June 1, 2001. Notwithstanding the provisions of this subsection, outpatient rates in effect as of June 30, 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006, subject to available appropriations, the commissioner shall increase outpatient service fees for services that may include clinic, emergency room, magnetic resonance imaging, and computerized axial tomography. [Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies, identifying such fee increases and the associated cost increase estimates.]

Sec. 114. Subsection (a) of section 17b-242 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and homemaker-home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. For the period from February 1, 1991, to January 31, 1992, inclusive, payment for each service to the state shall be based upon the rate for such service as determined by the Office of Health Care Access, except that for those providers whose Medicaid rates for the year ending January 31, 1991, exceed the median rate, no increase shall be allowed. For those providers whose rates for the year ending January 31, 1991, are below the median rate, increases shall not exceed the lower of the prior rate increased by the most recent annual increase in the consumer price index for urban

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consumers or the median rate. In no case shall any such rate exceed the eightieth percentile of rates in effect January 31, 1991, nor shall any rate exceed the charge to the general public for similar services. Rates effective February 1, 1992, shall be based upon rates as determined by the Office of Health Care Access, except that increases shall not exceed the prior year's rate increased by the most recent annual increase in the consumer price index for urban consumers and rates effective February 1, 1992, shall remain in effect through June 30, 1993. Rates effective July 1, 1993, shall be based upon rates as determined by the Office of Health Care Access except if the Medicaid rates for any service for the period ending June 30, 1993, exceed the median rate for such service, the increase effective July 1, 1993, shall not exceed one per cent. If the Medicaid rate for any service for the period ending June 30, 1993, is below the median rate, the increase effective July 1, 1993, shall not exceed the lower of the prior rate increased by one and one-half times the most recent annual increase in the consumer price index for urban consumers or the median rate plus one per cent. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually [increase any fee in the fee schedule based on an increase in the cost of services] modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to home health care agencies and homemaker-home health aide agencies in the aggregate and ensures patient access. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, as amended by this act, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. The commissioner may increase any fee payable to a home health care agency or homemaker-home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; (3)

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escort services; or (4) extended hour services. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or homemaker-home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months.

Sec. 115. Section 17b-261m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Commissioner of Social Services may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under Medicaid, HUSKY Plan, Parts A and B, and the Charter Oak Health Plan. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. Subject to approval by applicable federal authority, the Department of Social Services shall utilize the contracted organization's provider network and billing systems in the administration of the program. In order to

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implement the provisions of this section, the commissioner may establish rates of payment to providers of medical services under this section if the establishment of such rates is required to ensure that any contract entered into with an administrative services organization pursuant to this section is cost neutral to such providers in the aggregate and ensures patient access.

(b) Any contract entered into with an administrative services organization, pursuant to subsection (a) of this section, shall include a provision to reduce inappropriate use of hospital emergency department services. Such provision may include intensive case management services and a cost-sharing requirement.

Sec. 116. Section 17b-261n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Commissioner of Social Services shall, subject to federal approval, administer coverage under the Medicaid program for low-income adults in accordance with Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. To the extent permitted under federal law, eligibility for individuals covered pursuant to this section shall be based on the rules used to determine eligibility for the state-administered general assistance medical assistance program, including, but not limited to, the use of medically needy income limits, a one-hundred-fifty-dollars-per-month employment deduction and a three-month extension of assistance for individuals who become ineligible solely due to an increase in earnings. [The commissioner shall implement the provisions of this section while in the process of adopting necessary policies and procedures in regulation form in accordance with section 17b-10.] The commissioner may amend the Medicaid state plan to establish an alternative benefit package for individuals eligible for Medicaid in accordance with the provisions of this section and as permitted by federal law. For purposes of this section, "alternative benefit package" may include, but is not limited to,

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limits on any of the following: (1) Health care provider office visits; (2) independent therapy services; (3) hospital emergency department services; (4) inpatient hospital services; (5) outpatient hospital services; (6) medical equipment, devices and supplies; (7) ambulatory surgery center services; (8) pharmacy services; (9) nonemergency medical transportation; and (10) licensed home care agency services.

(b) The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall remain valid for three years following the date of publication in the Connecticut Law Journal unless otherwise provided for by the General Assembly. Notwithstanding the time frames established in subsection (c) of section 17b-10, the commissioner shall submit such policies and procedures in proposed regulation form to the legislative regulation review committee not later than three years following the date of publication of its intent to adopt regulations as provided for in this subsection. In the event that the commissioner is unable to submit proposed regulations prior to the expiration of the three-year time period as provided for in this subsection, the commissioner shall submit written notice, not later than thirty-five days prior to the date of expiration of such time period, to the legislative regulation review committee and the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies indicating that the department will not be able to submit the proposed regulations on or before such date and shall include in such notice (1) the reasons why the department will not submit the proposed regulations by such date, and (2) the date by which the department will submit the proposed regulations. The legislative regulation review committee may require

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the department to appear before the committee at a time prescribed by the committee to further explain such reasons and to respond to any questions by the committee about the policy. The legislative regulation review committee may request the joint standing committee of the General Assembly having cognizance of matters relating to human services to review the department's policy, the department's reasons for not submitting the proposed regulations by the date specified in this section and the date by which the department will submit the proposed regulations. Said joint standing committee may review the policy, such reasons and such date, may schedule a hearing thereon and may make a recommendation to the legislative regulation review committee.

(c) Effective July 1, 2011, no payment shall be made to a provider of medical services for services provided prior to April 1, 2010, to a recipient of benefits under this section.

Sec. 117. (NEW) (*Effective July 1, 2011*) Notwithstanding any provision of the general statutes, the Commissioners of Social Services, Correction and Mental Health and Addiction Services may establish or contract for the establishment of a chronic or convalescent nursing home on state-owned or private property to care for individuals who (1) require the level of care provided in a nursing home, and (2) are transitioning from a correctional facility in the state, or (3) receive services from the Department of Mental Health and Addiction Services. A nursing home developed under this section is not required to comply with the provisions of sections 17b-352 to 17b-354, inclusive, of the general statutes.

Sec. 118. Subsection (a) of section 17b-257b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Qualified aliens, as defined in Section 431 of Public Law 104-193,

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admitted into the United States on or after August 22, 1996, other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law who are (1) receiving home [care] and community-based services that are equivalent to the services provided under the Medicaid waiver portion of the Connecticut home-care program for the elderly, established pursuant to section 17b-342, as amended by this act, (2) receiving nursing facility care under the state-funded medical assistance program on [September 8, 2009] June 30, 2011, shall continue to receive coverage for such services or care for as long as the individual meets Medicaid eligibility requirements for such services or care except for alien status, or (3) are receiving nursing facility care and have applied for state-funded medical assistance before [September 8, 2009] June 1, 2011, and would otherwise be eligible for such assistance, shall be provided such assistance for as long as the individual meets Medicaid eligibility requirements for nursing facility care except for alien status, except such aliens who are (A) children and pregnant women, and (B) whose date of admission is less than five years before the date services are provided shall receive coverage until such time as the state plan amendment concerning federal funding for the provision of services to such aliens is approved.

Sec. 119. Subsection (a) of section 17b-257c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Commissioner of Social Services, after consultation with the Commissioner of Mental Health and Addiction Services and the Secretary of the Office of Policy and Management, may provide, within available appropriations, payments to long-term care facilities for the care of certain illegal immigrants who were admitted to a long-term care facility before July 1, 2011. Payments may be made to cover the costs of care, as well as other incidentals as determined by the

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Commissioner of Social Services, for illegal immigrants who have been admitted to an acute care or psychiatric hospital and for whom services available in a long-term care facility are an appropriate and cost-effective alternative. Such individuals must be otherwise eligible for Medicaid, have resided in this state for at least five years and be unable to return to their country of origin due to medical illness or regulations barring reentry of persons who are ill or disabled or based upon a decision by the Immigration and Naturalization Service not to proceed with deportation.

Sec. 120. Section 17b-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

A person whose application for state-administered general assistance cash [or medical] benefits is denied or whose receipt of such assistance is terminated or modified may request a hearing pursuant to section 17b-60. [, provided a recipient of medical benefits who seeks review of a denial of coverage for a specific medical service shall exhaust the grievance process available pursuant to section 17b-192 prior to requesting such a hearing.]

Sec. 121. Subsection (b) of section 17b-90 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) No person shall, except for purposes directly connected with the administration of programs of the Department of Social Services and in accordance with the regulations of the commissioner, solicit, disclose, receive or make use of, or authorize, knowingly permit, participate in or acquiesce in the use of, any list of the names of, or any information concerning, persons applying for or receiving assistance from the Department of Social Services or persons participating in a program administered by said department, directly or indirectly derived from the records, papers, files or communications of the state or its

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subdivisions or agencies, or acquired in the course of the performance of official duties. The Commissioner of Social Services shall disclose (1) to any authorized representative of the Labor Commissioner such information directly related to unemployment compensation, administered pursuant to chapter 567 or information necessary for implementation of sections 17b-688b, 17b-688c and 17b-688h and section 122 of public act 97-2 of the June 18 special session, (2) to any authorized representative of the Commissioner of Mental Health and Addiction Services any information necessary for the implementation and operation of the basic needs supplement program or [for the management of and payment for behavioral health services for applicants for and recipients of state-administered general assistance] the Medicaid program for low-income adults, established pursuant to section 17b-261n, as amended by this act, (3) to any authorized representative of the Commissioner of Administrative Services, or the Commissioner of Public Safety such information as the state Commissioner of Social Services determines is directly related to and necessary for the Department of Administrative Services or the Department of Public Safety for purposes of performing their functions of collecting social services recoveries and overpayments or amounts due as support in social services cases, investigating social services fraud or locating absent parents of public assistance recipients, (4) to any authorized representative of the Commissioner of Children and Families necessary information concerning a child or the immediate family of a child receiving services from the Department of Social Services, including safety net services, if the Commissioner of Children and Families or the Commissioner of Social Services has determined that imminent danger to such child's health, safety or welfare exists to target the services of the family services programs administered by the Department of Children and Families, (5) to a town official or other contractor or authorized representative of the Labor Commissioner such information concerning an applicant for or a recipient of [financial or medical] assistance under state-administered general

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assistance deemed necessary by said commissioners to carry out their respective responsibilities to serve such persons under the programs administered by the Labor Department that are designed to serve applicants for or recipients of state-administered general assistance, (6) to any authorized representative of the Commissioner of Mental Health and Addiction Services for the purposes of the behavioral health managed care program established by section 17a-453, (7) to any authorized representative of the Commissioner of Public Health to carry out his or her respective responsibilities under programs that regulate child day care services or youth camps, or (8) to a health insurance provider, in IV-D support cases, as defined in section 46b-231, information concerning a child and the custodial parent of such child that is necessary to enroll such child in a health insurance plan available through such provider when the noncustodial parent of such child is under court order to provide health insurance coverage but is unable to provide such information, provided the Commissioner of Social Services determines, after providing prior notice of the disclosure to such custodial parent and an opportunity for such parent to object, that such disclosure is in the best interests of the child. No such representative shall disclose any information obtained pursuant to this section, except as specified in this section. Any applicant for assistance provided through said department shall be notified that, if and when such applicant receives benefits, the department will be providing law enforcement officials with the address of such applicant upon the request of any such official pursuant to section 17b-16a.

Sec. 122. Subsection (b) of section 17a-460c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) The agreements and other contractual arrangements identified in subsection (a) of this section may include plans and arrangements certified by the Department of Social Services, the Department of

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Mental Health and Addiction Services, or the federal Centers for Medicare and Medicaid Services, to provide services to Medicaid, Medicare, [state-administered general assistance,] Department of Mental Health and Addiction Services or Centers for Medicare and Medicaid Services beneficiaries, as well as private plans and arrangements satisfactory to the commissioner.

Sec. 123. Subsection (b) of section 12-202a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) Notwithstanding the provisions of subsection (a) of this section, the tax shall not apply to:

(1) Any new or renewal contract or policy entered into with the state on or after July 1, 1997, to provide health care coverage to state employees, retirees and their dependents;

(2) Any subscriber charges received from the federal government to provide coverage for Medicare patients;

(3) Any subscriber charges received under a contract or policy entered into with the state to provide health care coverage to Medicaid recipients which charges are attributable to a period on or after January 1, 1998;

(4) Any new or renewal contract or policy entered into with the state on or after April 1, 1998, to provide health care coverage to eligible beneficiaries under the HUSKY Plan Part A, HUSKY Part B, or the HUSKY Plus programs, each as defined in section 17b-290;

[(5) Any new or renewal contract or policy entered into with the state on or after April 1, 1998, to provide health care coverage to recipients of state-administered general assistance pursuant to section 17b-192;]

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[(6)] (5) Any new or renewal contract or policy entered into with the state on or after February 1, 2000, to provide health care coverage to retired teachers, spouses or surviving spouses covered by plans offered by the state teachers' retirement system;

[(7)] (6) Any new or renewal contract or policy entered into on or after July 1, 2001, to provide health care coverage to employees of a municipality and their dependents under a plan procured pursuant to section 5-259;

[(8)] (7) Any new or renewal contract or policy entered into on or after July 1, 2001, to provide health care coverage to employees of nonprofit organizations and their dependents under a plan procured pursuant to section 5-259;

[(9)] (8) Any new or renewal contract or policy entered into on or after July 1, 2003, to provide health care coverage to individuals eligible for a health coverage tax credit and their dependents under a plan procured pursuant to section 5-259;

[(10)] (9) Any new or renewal contract or policy entered into on or after July 1, 2005, to provide health care coverage to employees of community action agencies and their dependents under a plan procured pursuant to section 5-259; or

[(11)] (10) Any new or renewal contract or policy entered into on or after July 1, 2005, to provide health care coverage to retired members and their dependents under a plan procured pursuant to section 5-259.

Sec. 124. Subsection (b) of section 10a-132e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) The program established pursuant to subsection (a) of this section shall: (1) Arrange for licensed physicians, pharmacists and

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nurses to conduct in person educational visits with prescribing practitioners, utilizing evidence-based materials, borrowing methods from behavioral science and educational theory and, when appropriate, utilizing pharmaceutical industry data and outreach techniques; (2) inform prescribing practitioners about drug marketing that is designed to prevent competition to brand name drugs from generic or other therapeutically-equivalent pharmaceutical alternatives or other evidence-based treatment options; and (3) provide outreach and education to licensed physicians and other health care practitioners who are participating providers in state-funded health care programs, including, but not limited to, Medicaid, the HUSKY Plan, Parts A and B, [the state-administered general assistance program,] the Charter Oak Health Plan, the ConnPACE program, the Department of Correction inmate health services program and the state employees' health insurance plan.

Sec. 125. Subsection (e) of section 17b-274d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(e) The Department of Social Services, in consultation with the Pharmaceutical and Therapeutics Committee, may adopt preferred drug lists for use in the Medicaid [, state-administered general assistance] and ConnPACE programs. To the extent feasible, the department shall review all drugs included on the preferred drug lists at least every twelve months, and may recommend additions to, and deletions from, the preferred drug lists, to ensure that the preferred drug lists provide for medically appropriate drug therapies for Medicaid [, state-administered general assistance] and ConnPACE patients. For the fiscal year ending June 30, 2004, such drug lists shall be limited to use in the Medicaid and ConnPACE programs and cover three classes of drugs, including proton pump inhibitors and two other classes of drugs determined by the Commissioner of Social Services.

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Not later than June 30, 2005, the Department of Social Services, in consultation with the Pharmaceutical and Therapeutic Committee shall expand such drug lists to include other classes of drugs, except as provided in subsection (f) of this section, in order to achieve savings reflected in the amounts appropriated to the department, for the various components of the program, in the state budget act.

Sec. 126. Section 17b-274a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The Commissioner of Social Services may establish maximum allowable costs to be paid under the Medicaid, [state-administered general assistance,] ConnPACE and Connecticut AIDS drug assistance programs for generic prescription drugs based on, but not limited to, actual acquisition costs. The department shall implement and maintain a procedure to review and update the maximum allowable cost list at least annually, and shall report annually to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies on its activities pursuant to this section.

Sec. 127. Subsection (a) of section 17b-274c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Commissioner of Social Services may establish a voluntary mail order option for any maintenance prescription drug covered under the Medicaid, [state-administered general assistance,] ConnPACE or Connecticut AIDS drug assistance programs.

Sec. 128. Section 17b-274 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Division of Criminal Justice shall periodically investigate pharmacies to ensure that the state is not billed for a brand name drug

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product when a less expensive generic substitute drug product is dispensed to a Medicaid recipient. The Commissioner of Social Services shall cooperate and provide information as requested by such division.

(b) A licensed medical practitioner may specify in writing or by a telephonic or electronic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid [, state-administered general assistance,] or ConnPACE recipient, provided (1) the practitioner specifies the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic drug product substitution, and (2) the phrase "brand medically necessary" shall be in the practitioner's handwriting on the prescription form or, if the prohibition was communicated by telephonic communication, in the pharmacist's handwriting on such form, and shall not be preprinted or stamped or initialed on such form. If the practitioner specifies by telephonic communication that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid [, state-administered general assistance,] or ConnPACE recipient, written certification in the practitioner's handwriting bearing the phrase "brand medically necessary" shall be sent to the dispensing pharmacy within ten days. A pharmacist shall dispense a generically equivalent drug product for any drug listed in accordance with the Code of Federal Regulations Title 42 Part 447.332 for a drug prescribed for a Medicaid, state-administered general assistance, or ConnPACE recipient unless the phrase "brand medically necessary" is ordered in accordance with this subsection and such pharmacist has received approval to dispense the brand name drug product in accordance with subsection (c) of this section.

(c) The Commissioner of Social Services shall implement a procedure by which a pharmacist shall obtain approval from an

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independent pharmacy consultant acting on behalf of the Department of Social Services, under an administrative services only contract, whenever the pharmacist dispenses a brand name drug product to a Medicaid [, state-administered general assistance,] or ConnPACE recipient and a chemically equivalent generic drug product substitution is available. The length of authorization for brand name drugs shall be in accordance with section 17b-491a. In cases where the brand name drug is less costly than the chemically equivalent generic drug when factoring in manufacturers' rebates, the pharmacist shall dispense the brand name drug. If such approval is not granted or denied within two hours of receipt by the commissioner of the request for approval, it shall be deemed granted. Notwithstanding any provision of this section, a pharmacist shall not dispense any initial maintenance drug prescription for which there is a chemically equivalent generic substitution that is for less than fifteen days without the department's granting of prior authorization, provided prior authorization shall not otherwise be required for atypical antipsychotic drugs if the individual is currently taking such drug at the time the pharmacist receives the prescription. The pharmacist may appeal a denial of reimbursement to the department based on the failure of such pharmacist to substitute a generic drug product in accordance with this section.

(d) A licensed medical practitioner shall disclose to the Department of Social Services or such consultant, upon request, the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic drug product substitution. The Commissioner of Social Services shall establish a procedure by which such a practitioner may appeal a determination that a chemically equivalent generic drug product substitution is required for a Medicaid [, state-administered general assistance,] or ConnPACE recipient.

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Sec. 129. Section 17b-274e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

A pharmacist, when filling a prescription under the Medicaid, ConnPACE [,] or Connecticut AIDS drug assistance [or the state-administered general assistance] programs, shall fill such prescription utilizing the most cost-efficient dosage, consistent with the prescription of a prescribing practitioner as defined in section 20-571, unless such pharmacist receives permission to do otherwise pursuant to the prior authorization requirements set forth in sections 17b-274 and 17b-491a, as amended by this act.

Sec. 130. Subsection (b) of section 17b-276 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) Notwithstanding any other provision of the general statutes, for purposes of administering medical assistance programs, including, but not limited to, [the state-administered general assistance program and] programs administered pursuant to Title XIX or Title XXI of the Social Security Act, the Department of Social Services shall be the sole state agency that sets emergency and nonemergency medical transportation fees or fee schedules for any transportation services that are reimbursed by the department for said medical assistance programs.

Sec. 131. Section 17b-491b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The maximum allowable cost paid for Factor VIII pharmaceuticals under the Medicaid [, state-administered general assistance,] and ConnPACE programs shall be the actual acquisition cost plus eight per cent. The Commissioner of Social Services may designate specific suppliers of Factor VIII pharmaceuticals from which a dispensing pharmacy shall order the prescription to be delivered to the pharmacy

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and billed by the supplier to the Department of Social Services. If the commissioner so designates specific suppliers of Factor VIII pharmaceuticals, the department shall pay the dispensing pharmacy a handling fee equal to eight per cent of the actual acquisition cost for such prescription.

Sec. 132. Subsection (a) of section 17b-694 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Labor Commissioner, in consultation with the Commissioners of Social Services and Mental Health, shall administer a grant program, within available appropriations, to fund employment placement projects for recipients of state-administered general assistance [, cash assistance or medical assistance] or recipients of Medicaid who are eighteen to twenty years of age. A grant may be awarded to (1) a municipality or group of towns which form a region based on a project plan providing education, training or other assistance in securing employment, (2) a private substance abuse or mental health services provider based on a project plan incorporating job placement in the treatment process, or (3) a nonprofit organization providing employment services when no municipality or group of towns elect to apply for such a grant for a given geographic area. A plan may include cash incentives as a supplement to wages for recipients who work.

Sec. 133. Subdivision (4) of subsection (a) of section 19a-673 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(4) "Uninsured patient" means any person who is liable for one or more hospital charges whose income is at or below two hundred fifty per cent of the poverty income guidelines who (A) has applied and been denied eligibility for any medical or health care coverage

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provided under [the state-administered general assistance program or] the Medicaid program due to failure to satisfy income or other eligibility requirements, and (B) is not eligible for coverage for hospital services under the Medicare or CHAMPUS programs, or under any Medicaid or health insurance program of any other nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to, workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

Sec. 134. Subsections (c) and (d) of section 19a-718 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The board of directors shall develop recommendations to ensure that the HUSKY Plan Part A and Part B, and Medicaid [and state-administered general assistance] programs participate in the Sustinet Plan. Such recommendations shall also ensure that HUSKY Plan Part A and Part B benefits are extended, to the extent permitted by federal law, to adults with income at or below three hundred per cent of the federal poverty level.

(d) The board of directors shall make recommendations to ensure that on and after July 1, 2012, state residents who are not offered employer-sponsored insurance and who do not qualify for HUSKY Plan Part A and Part B [,] or Medicaid [or state-administered general assistance] are permitted to enroll in the Sustinet Plan. Such recommendations shall ensure that premium variation based on member characteristics does not exceed, in total amount or in consideration of individual health risk, the variation permitted for a small employer carrier, as defined in subdivision (16) of section 38a-564.

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Sec. 135. Subdivision (12) of section 22-380e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(12) "Low-income person" means a recipient of or a person eligible for one of the following public assistance programs:

(A) The supplemental nutrition assistance program authorized by Title XIII of the federal Food and Agriculture Act of 1977, 7 USC 2011 et seq.;

(B) The federal Temporary Assistance for Needy Families Act authorized by 42 USC 601 et seq.;

(C) The Medicaid program authorized by Title XIX of the federal Social Security Act;

(D) The HUSKY Plan Part A;

(E) The [medical assistance or cash assistance components of the] state-administered general assistance program;

(F) The state supplement program; or

(G) Any other public assistance program that the commissioner determines to qualify a person as a low-income person.

Sec. 136. Subsection (b) of section 38a-472 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) Whenever there is in existence a contract by an insurer for payment to, or on behalf of, an applicant or recipient of medical assistance under [the state-administered general assistance program or] the Medicaid program under said contract on account of bills incurred by the applicant or recipient for medical services, including,

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but not limited to, physician services, nursing services, pharmaceutical services, surgical care and hospital care, the assignment of the benefits of the contract by such applicant or recipient or his legally liable relative pursuant to section 17b-265, as amended by this act, shall, upon receipt of notice from the assignee, be authority for payment by the insurer directly to the assignee. If notice is provided by the assignee to the insurer in accordance with the provisions of section 17b-265, as amended by this act, the insurer shall be liable to the assignee for any amount payable to the assignee under the contract.

Sec. 137. Subsection (b) of section 38a-472d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) The information on the department's Internet web site shall reference the availability and general eligibility requirements of (1) programs administered by the Department of Social Services, including, but not limited to, the Medicaid program [,] and the HUSKY Plan, Part A and Part B, [and the state-administered general assistance program,] (2) health insurance coverage provided by the Comptroller under subsection (i) of section 5-259, (3) health insurance coverage available under comprehensive health care plans issued pursuant to part IV of this chapter, and (4) other health insurance coverage offered through local, state or federal agencies or through entities licensed in this state. The commissioner shall update the information on the web site at least quarterly.

Sec. 138. Subsection (b) of section 38a-556a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) Said association shall, in consultation with the Insurance Commissioner and the Healthcare Advocate, develop, within available appropriations, a web site, telephone number or other method to serve

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as a clearinghouse for information about individual and small employer health insurance policies and health care plans that are available to consumers in this state, including, but not limited to, the Medicaid program, the HUSKY Plan, [state-administered general assistance,] the Charter Oak Health Plan set forth in section 17b-311, as amended by this act, the Municipal Employee Health Insurance Plan set forth in subsection (i) of section 5-259, and any individual or small employer health insurance policies or health care plans an insurer, health care center or other entity chooses to list with the Connecticut Clearinghouse.

Sec. 139. Subsection (a) of section 17b-191 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Notwithstanding the provisions of sections 17b-190, 17b-195 and 17b-196, the Commissioner of Social Services shall operate a state-administered general assistance program in accordance with this section and sections 17b-131, [17b-192 to] 17b-193, as amended by this act, 17b-194, [inclusive,] 17b-197 and 17b-198. Notwithstanding any provision of the general statutes, on and after October 1, 2003, no town shall be reimbursed by the state for any general assistance medical benefits incurred after September 30, 2003, and on and after March 1, 2004, no town shall be reimbursed by the state for any general assistance cash benefits or general assistance program administrative costs incurred after February 29, 2004.

Sec. 140. Section 17b-689b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The Commissioner of Social Services may implement the provisions of sections [17b-192,] 17b-194 and 17b-195, subsection (a) of section 17b-198 and section 25 of public act 96-268 while in the process of adopting policy and procedures in regulation form, provided notice of

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intention to adopt the regulations is published in the Connecticut Law Journal within twenty days of implementation.

Sec. 141. Section 17b-10a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures necessary to administer [subsection (b) of section 17b-192,] section 17b-197, subsection (d) of section 17b-266, section 17b-280a, as amended by this act, subsection (a) of section 17b-295, as amended by this act, and subsection (c) of section 17b-311, as amended by this act, while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 142. Subsection (e) of section 17b-491 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(e) Participation by a pharmaceutical manufacturer shall require that the department shall receive a rebate from the pharmaceutical manufacturer for prescriptions covered under the program. [and for prescriptions covered by the department pursuant to subsection (c) of section 17b-265e.] Rebate amounts for brand name prescription drugs shall be equal to those under the Medicaid program. Rebate amounts for generic prescription drugs shall be established by the commissioner, provided such amounts may not be less than those under the Medicaid program. A participating pharmaceutical manufacturer shall make quarterly rebate payments to the department for the total number of dosage units of each form and strength of a prescription drug which the department reports as reimbursed to

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providers of prescription drugs, provided such payments shall not be due until thirty days following the manufacturer's receipt of utilization data from the department including the number of dosage units reimbursed to providers of prescription drugs during the quarter for which payment is due. The department may enter into contracts for supplemental rebates for drugs that are on a preferred drug list or formulary established by the department.

Sec. 143. Section 17b-499a of the general statutes is amended by adding subsection (e) as follows (*Effective July 1, 2011*):

(NEW) (e) The Commissioner of Social Services shall contract with a pharmacy organization, which may include a school of pharmacy, to provide Medicaid therapy management services, including, but not limited to, (1) a review of the medical and prescription history of recipients of benefits under the Medicaid program, and (2) the development of patient medication action plans to reduce adverse medication interaction and related health problems.

Sec. 144. Section 17b-8 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Commissioner of Social Services shall submit an application for a federal waiver of any assistance program requirements, except such application pertaining to routine operational issues, and any proposed amendment to the Medicaid state plan to make a change in program requirements that would have required a waiver were it not for the passage of the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies prior to the submission of such application or proposed amendment to the federal government. Not later than thirty days after the date of their receipt of

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such application or proposed amendment, the joint standing committees shall: (1) Hold a public hearing on the waiver application [, and (2) thereafter] or, (2) in the case of a proposed amendment to the Medicaid state plan, notify the Commissioner of Social Services whether or not said joint standing committees intend to hold a public hearing. Any notice to the commissioner indicating that the joint standing committees intend to hold a public hearing on a proposed amendment to the Medicaid state plan shall state the date on which the joint standing committees intend to hold such public hearing, which shall not be later than sixty days after the joint standing committees' receipt of the proposed amendment. At the conclusion of a public hearing held in accordance with the provisions of this section, the joint standing committees shall advise the commissioner of their approval, denial or modifications, if any, of the commissioner's waiver application or proposed amendment. If the joint standing committees advise the commissioner of their denial of the commissioner's waiver application or proposed amendment, the commissioner shall not submit the application for a federal waiver or proposed amendment to the federal government. If such committees do not concur, the committee chairpersons shall appoint a committee of conference which shall be composed of three members from each joint standing committee. At least one member appointed from each joint standing committee shall be a member of the minority party. The report of the committee of conference shall be made to each joint standing committee, which shall vote to accept or reject the report. The report of the committee of conference may not be amended. If a joint standing committee rejects the report of the committee of conference, that joint standing committee shall notify the commissioner of the rejection and the commissioner's waiver application or proposed amendment shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the commissioner of their approval, denial or modifications, if any, of the

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commissioner's waiver application or proposed amendment. If the joint standing committees do not so advise the commissioner during the thirty-day period, the waiver application or proposed amendment shall be deemed approved. Any application for a federal waiver or proposed amendment submitted to the federal government by the commissioner, pursuant to this section, shall be in accordance with the approval or modifications, if any, of the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

(b) If in developing the budget for the department for the next fiscal year, the commissioner contemplates applying for a federal waiver or submitting a proposed amendment to the federal government, the commissioner shall notify the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and the joint standing committee of the General Assembly having cognizance of matters relating to human services of the possibility of such application or proposed amendment.

(c) Prior to submission of an application for a waiver from federal law or proposed amendment to the joint standing committees of the General Assembly under subsection (a) of this section, the Commissioner of Social Services shall publish a notice that the commissioner intends to seek such a waiver or submit a proposed amendment to the federal government in the Connecticut Law Journal, along with a summary of the provisions of the waiver application or the proposed amendment and the manner in which individuals may submit comments. The commissioner shall allow fifteen days for written comments on the waiver application or proposed amendment prior to submission of the application for a waiver or proposed amendment to the General Assembly under subsection (a) of this section and shall include all written comments with the waiver application or proposed amendment in the submission to the General

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Assembly.

(d) The commissioner shall include with any waiver application or proposed amendment submitted to the federal government pursuant to this section: (1) Any written comments received pursuant to subsection (c) of this section; and (2) a complete transcript of the joint standing committee proceedings held pursuant to subsection (a) of this section, including any additional written comments submitted to the joint standing committees at such proceedings. The joint standing committees shall transmit any such materials to the commissioner for inclusion with any such waiver application or proposed amendment.

Sec. 145. Section 17a-317 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Effective July 1, [2011] 2013, there shall be established a Department on Aging [which] that shall be under the direction and supervision of the Commissioner on Aging who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, with the powers and duties prescribed in said sections. The commissioner shall be knowledgeable and experienced with respect to the conditions and needs of elderly persons and shall serve on a full-time basis.

(b) The Commissioner on Aging shall administer all laws under the jurisdiction of the Department on Aging and shall employ the most efficient and practical means for the provision of care and protection of elderly persons. The commissioner shall have the power and duty to do the following: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as necessary to implement the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of

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the department; (5) contract for facilities, services and programs to implement the purposes of the department; (6) act as advocate for necessary additional comprehensive and coordinated programs for elderly persons; (7) assist and advise all appropriate state, federal, local and area planning agencies for elderly persons in the performance of their functions and duties pursuant to federal law and regulation; (8) plan services and programs for elderly persons; (9) coordinate outreach activities by public and private agencies serving elderly persons; and (10) consult and cooperate with area and private planning agencies.

(c) The functions, powers, duties and personnel of the Division of Aging Services of the Department of Social Services, or any subsequent division or portion of a division with similar functions, powers, personnel and duties, shall be transferred to the Department on Aging pursuant to the provisions of sections 4-38d, 4-38e and 4-39.

(d) The Department of Social Services shall administer programs under the jurisdiction of the Department on Aging until the Commissioner on Aging is appointed and administrative staff are hired.

(e) The Governor may, with the approval of the Finance Advisory Committee, transfer funds between the Department of Social Services and the Department on Aging pursuant to subsection (b) of section 4-87 during the fiscal year ending June 30, [2012] 2014.

(f) Any order or regulation of the Department of Social Services or the Commission on Aging that is in force on July 1, [2011] 2013, shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 146. Section 17b-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2013*):

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(a) There is established a Department of Social Services. The department head shall be the Commissioner of Social Services, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, with the powers and duties therein prescribed.

(b) The Department of Social Services shall constitute a successor department to the Department of Income Maintenance [L] and the Department of Human Resources [and the Department on Aging] in accordance with the provisions of sections 4-38d and 4-39.

(c) Wherever the words "Commissioner of Income Maintenance" [L] or "Commissioner of Human Resources" [or "Commissioner on Aging"] are used in the general statutes, the words "Commissioner of Social Services" shall be substituted in lieu thereof. Wherever the words "Department of Income Maintenance" [L] or "Department of Human Resources" [or "Department on Aging"] are used in the general statutes, "Department of Social Services" shall be substituted in lieu thereof.

(d) [Any] Subject to the provisions of section 17a-317, as amended by this act, any order or regulation of the Department of Income Maintenance, the Department of Human Resources or the Department on Aging which is in force on July 1, 1993, shall continue in force and effect as an order or regulation of the Department of Social Services until amended, repealed or superseded pursuant to law. Where any order or regulation of said departments conflict, the Commissioner of Social Services may implement policies and procedures consistent with the provisions of public act 93-262 while in the process of adopting the policy or procedure in regulation form, provided notice of intention to adopt the regulations is printed in the Connecticut Law Journal within twenty days of implementation. The policy or procedure shall be valid until the time final regulations are effective.

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Sec. 147. Section 38a-490a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide [(1)] coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. [, and (2)] No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section. Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 148. Section 38a-516a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide [(1)] coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. [, and

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(2)] No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section. Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period, except that for a child with autism spectrum disorders, as defined in section 38a-514b, who is receiving early intervention services as defined in section 17a-248, the maximum benefit available through early intervention providers shall be fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child over the total three-year period as provided for in section 38a-514b. Nothing in this section shall be construed to increase the amount of coverage required for autism spectrum disorders for any child beyond the amounts set forth in section 38a-514b. Any coverage provided for autism spectrum disorders through an individualized family service plan pursuant to section 17a-248e shall be credited toward the coverage amounts required under section 38a-514b. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 149. Section 12-818 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

For each of the fiscal years ending June 30, 2010, and June 30, 2011, the Connecticut Lottery Corporation shall transfer one million nine hundred thousand dollars of the revenue received from the sale of lottery tickets to the chronic gamblers treatment rehabilitation account created pursuant to section 17a-713. For the fiscal year ending June 30, 2012, and each fiscal year thereafter, the Connecticut Lottery Corporation shall transfer one million [five] nine hundred thousand

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dollars of the revenue received from the sale of lottery tickets to the chronic gamblers treatment rehabilitation account created pursuant to section 17a-713.

Sec. 150. Section 20-619 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) For the purposes of section 20-579 and this section:

(1) "Brand name" means the proprietary or trade name selected by the manufacturer and placed upon a drug product, its container, label or wrapping at the time of packaging;

(2) "Generic name" means the established name designated in the official United States [Pharmacopoeia/National Formulary] Pharmacopoeia-National Formulary, official Homeopathic Pharmacopoeia of the United States, or official United States [adopted names] Adopted Names or any supplement to any of [them] said publications;

(3) "Therapeutically equivalent" means drug products that are approved under the provisions of the federal Food, Drug and [Cosmetics] Cosmetic Act for interstate distribution and that will provide essentially the same efficacy and toxicity when administered to an individual in the same dosage regimen; [and]

(4) "Dosage form" means the physical formulation or medium in which the product is intended, manufactured and made available for use, including, but not limited to, tablets, capsules, oral solutions, aerosol, inhalers, gels, lotions, creams, ointments, transdermals and suppositories, and the particular form of any physical formulation or medium that uses a specific technology or mechanism to control, enhance or direct the release, targeting, systemic absorption, or other delivery of a dosage regimen in the body;

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(5) "Epilepsy" means a neurological condition characterized by recurrent seizures;

(6) "Seizures" means a disturbance in the electrical activity of the brain; and

(7) "Antiepileptic drug" means a drug prescribed for the treatment of epilepsy or a drug used to prevent seizures.

(b) Except as limited by subsections (c), [and] (e) and (i) of this section, unless the purchaser instructs otherwise, the pharmacist may substitute a generic drug product with the same strength, quantity, dose and dosage form as the prescribed drug product which is, in the pharmacist's professional opinion, therapeutically equivalent. When the prescribing practitioner is not reasonably available for consultation and the prescribed drug does not use a unique delivery system technology, the pharmacist may substitute an oral tablet, capsule or liquid form of the prescribed drug as long as the form dispensed has the same strength, dose and dose schedule and is therapeutically equivalent to the drug prescribed. The pharmacist shall inform the patient or a representative of the patient, and the practitioner of the substitution at the earliest reasonable time.

(c) A prescribing practitioner may specify in writing or by a telephonic or other electronic communication that there shall be no substitution for the specified brand name drug product in any prescription, provided (1) in any prescription for a Medicaid [, state-administered general assistance,] or ConnPACE recipient, such practitioner specifies the basis on which the brand name drug product and dosage form is medically necessary in comparison to a chemically equivalent generic name drug product substitution, and (2) the phrase "BRAND MEDICALLY NECESSARY", shall be in the practitioner's handwriting on the prescription form or on an electronically-produced copy of the prescription form or, if the prohibition was communicated

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by telephonic or other electronic communication that did not reproduce the practitioner's handwriting, a statement to that effect appears on the form. The phrase "BRAND MEDICALLY NECESSARY" shall not be preprinted or stamped or initialed on the form. If the practitioner specifies by telephonic or other electronic communication that did not reproduce the practitioner's handwriting that there shall be no substitution for the specified brand name drug product in any prescription for a Medicaid [, state-administered general assistance,] or ConnPACE recipient, written certification in the practitioner's handwriting bearing the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the dispensing pharmacy [within] not later than ten days after the date of such communication.

(d) Each pharmacy shall post a sign in a location easily seen by patrons at the counter where prescriptions are dispensed stating that, "THIS PHARMACY MAY BE ABLE TO SUBSTITUTE A LESS EXPENSIVE DRUG PRODUCT WHICH IS THERAPEUTICALLY EQUIVALENT TO THE ONE PRESCRIBED BY YOUR DOCTOR UNLESS YOU DO NOT APPROVE." The printing on the sign shall be in block letters not less than one inch in height.

(e) A pharmacist may substitute a drug product under subsection (b) of this section only when there will be a savings in cost passed on to the purchaser. The pharmacist shall disclose the amount of the savings at the request of the patient.

(f) Except as provided in subsection (g) of this section, when a pharmacist dispenses a substitute drug product as authorized by subsection (b) of this section, the pharmacist shall label the prescription container with the name of the dispensed drug product. If the dispensed drug product does not have a brand name, the prescription label shall indicate the generic name of the drug product dispensed along with the name of the drug manufacturer or distributor.

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(g) A prescription dispensed by a pharmacist shall bear upon the label the name of the drug in the container unless the prescribing practitioner writes "DO NOT LABEL", or words of similar import, on the prescription or so designates in an oral or electronic transmission of the prescription.

(h) Neither the failure to instruct by the purchaser as provided in subsection (b) of this section nor the fact that a sign has been posted as provided in subsection (d) of this section shall be a defense on the part of a pharmacist against a suit brought by any such purchaser.

(i) Upon the initial filling or renewal of a prescription that contains a statistical information code based upon the most recent edition of the International Classification of Diseases indicating the prescribed drug is used for the treatment of epilepsy or to prevent seizures, a pharmacist shall not fill the prescription by using a different drug manufacturer or distributor of the prescribed drug, unless the pharmacist (1) provides prior notice of the use of a different drug manufacturer or distributor to the patient and the prescribing practitioner, and (2) obtains the written consent of the patient's prescribing practitioner. For purposes of obtaining the consent of the patient's prescribing practitioner required by this subsection, a pharmacist shall notify the prescribing practitioner via electronic mail or facsimile transmission. If the prescribing practitioner does not provide the necessary consent, the pharmacist shall fill the prescription without such substitution or use of a different drug manufacturer or distributor or return the prescription to the patient or to the patient's representative for filling at another pharmacy. If a pharmacist is unable to contact the patient's prescribing practitioner after making reasonable efforts to do so, such pharmacist may exercise professional judgment in refilling a prescription in accordance with the provisions of subsection (b) of section 20-616. For purposes of this subsection, "pharmacy" means a place of business where drugs and devices may

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be sold at retail and for which a pharmacy license was issued pursuant to section 20-594, including a hospital-based pharmacy when such pharmacy is filling prescriptions for employees and outpatient care, and a mail order pharmacy licensed by this state to distribute in this state. "Pharmacy" does not include a pharmacy serving patients in a long-term care facility, other institutional facility or a pharmacy that provides prescriptions for inpatient hospitals.

[(i)] (j) The commissioner, with the advice and assistance of the commission, shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this section.

Sec. 151. Section 17b-493 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

A pharmacist shall, except as limited by [subsection (c)] subsections (c), (e) and (i) of section 20-619, as amended by this act, and section 17b-274, as amended by this act, substitute a therapeutically and chemically equivalent generic drug product for a prescribed drug product when filling a prescription for an eligible person under the program.

Sec. 152. Subsection (b) of section 19a-323 of the general statutes, as amended by section 129 of public act 11-6, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) If death occurred in this state, the death certificate required by law shall be filed with the registrar of vital statistics for the town in which such person died, if known, or, if not known, for the town in which the body was found. The Chief Medical Examiner, Deputy Chief Medical Examiner, associate medical examiner, [or] an authorized assistant medical examiner or other authorized designee shall complete the cremation certificate, stating that such medical examiner or other authorized designee has made inquiry into the cause and

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manner of death and is of the opinion that no further examination or judicial inquiry is necessary. The cremation certificate shall be submitted to the registrar of vital statistics of the town in which such person died, if known, or, if not known, of the town in which the body was found, or with the registrar of vital statistics of the town in which the funeral director having charge of the body is located. Upon receipt of the cremation certificate, the registrar shall authorize such certificate, keep such certificate on permanent record, and issue a cremation permit, except that if the cremation certificate is submitted to the registrar of the town where the funeral director is located, such certificate shall be forwarded to the registrar of the town where the person died to be kept on permanent record. If a cremation permit must be obtained during the hours that the office of the local registrar of the town where death occurred is closed, a subregistrar appointed to serve such town may authorize such cremation permit upon receipt and review of a properly completed cremation permit and cremation certificate. A subregistrar who is licensed as a funeral director or embalmer pursuant to chapter 385, or the employee or agent of such funeral director or embalmer shall not issue a cremation permit to himself or herself. A subregistrar shall forward the cremation certificate to the local registrar of the town where death occurred, not later than seven days after receiving such certificate. The estate of the deceased person, if any, shall pay the sum of one hundred fifty dollars for the issuance of the cremation certificate, provided the Office of the Chief Medical Examiner shall not assess any fees for costs that are associated with the cremation of a stillborn fetus. No cremation certificate shall be required for a permit to cremate the remains of bodies pursuant to section 19a-270a. When the cremation certificate is submitted to a town other than that where the person died, the registrar of vital statistics for such other town shall ascertain from the original removal, transit and burial permit that the certificates required by the state statutes have been received and recorded, that the body has been prepared in accordance with the Public Health Code and that

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the entry regarding the place of disposal is correct. Whenever the registrar finds that the place of disposal is incorrect, the registrar shall issue a corrected removal, transit and burial permit and, after inscribing and recording the original permit in the manner prescribed for sextons' reports under section 7-66, shall then immediately give written notice to the registrar for the town where the death occurred of the change in place of disposal stating the name and place of the crematory and the date of cremation. Such written notice shall be sufficient authorization to correct these items on the original certificate of death. The fee for a cremation permit shall be three dollars and for the written notice one dollar. The Department of Public Health shall provide forms for cremation permits, which shall not be the same as for regular burial permits and shall include space to record information about the intended manner of disposition of the cremated remains, and such blanks and books as may be required by the registrars.

Sec. 153. Section 17b-301a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

As used in this section and section 17b-301b:

(1) "Knowing" and "knowingly" means that a person, with respect to information: (A) Has actual knowledge of the information; (B) acts in deliberate ignorance of the truth or falsity of the information; or (C) acts in reckless disregard of the truth or falsity of the information, without regard to whether the person intends to defraud;

(2) "Claim" (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the state has title to the money or property that (i) is presented to an officer, employee or agent of the state, or (ii) is made to a contractor, grantee or other recipient, if the money or property is to be spent or used on the state's behalf or to advance a state program or interest, and

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if the state provides or has provided any portion of the money or property that is requested or demanded, or if the state will reimburse such contractor, grantee or other recipient for any portion of the money or property that is requested or demanded, (B) does not include a request or demand for money or property that the state has paid to an individual as compensation for state employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) "Person" means any natural person, corporation, limited liability company, firm, association, organization, partnership, business, trust or other legal entity;

(4) "State" means the state of Connecticut, any agency or department of the state or any quasi-public agency, as defined in section 1-120; [.]

(5) "Obligation" means an established duty, whether fixed or not, arising from (A) an express or implied contractual, grantor-grantee or licensor-licensee relationship, (B) a fee-based or similar relationship, (C) statute or regulation, or (D) the retention of an overpayment; and

(6) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

Sec. 154. Section 17b-301b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No person shall:

(1) Knowingly present, or cause to be presented, [to an officer or employee of the state] a false or fraudulent claim for payment or approval under a medical assistance program administered by the Department of Social Services;

(2) Knowingly make, use or cause to be made or used, a false record

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or statement [to secure the payment or approval by the state of] material to a false or fraudulent claim under a medical assistance program administered by the Department of Social Services;

(3) Conspire to [defraud the state by securing the allowance or payment of a false or fraudulent claim under a medical assistance program administered by the Department of Social Services] commit a violation of this section;

(4) Having possession, custody or control of property or money used, or to be used, by the state relative to a medical assistance program administered by the Department of Social Services, and intending to defraud the state or wilfully to conceal the property, deliver or cause to be delivered less property than the amount for which the person receives a certificate or receipt;

(5) Being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state relative to a medical assistance program administered by the Department of Social Services and intending to defraud the state, make or deliver such document without completely knowing that the information on the document is true;

(6) Knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the state relative to a medical assistance program administered by the Department of Social Services, who lawfully may not sell or pledge the property; [or]

(7) Knowingly make, use or cause to be made or used, a false record or statement [to conceal, avoid or decrease] material to an obligation to pay or transmit money or property to the state under a medical assistance program administered by the Department of Social Services;
or

(8) Knowingly conceal or knowingly and improperly avoid or

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decrease an obligation to pay or transmit money or property to the state under a medical assistance program administered by the Department of Social Services.

(b) Any person who violates the provisions of subsection (a) of this section shall be liable to the state for: (1) A civil penalty of not less than five thousand five hundred dollars or more than [ten] eleven thousand dollars, or as adjusted from time to time by the federal Civil Penalties Inflation Adjustment Act of 1990, 28 USC 2461, (2) three times the amount of damages that the state sustains because of the act of that person, and (3) the costs of investigation and prosecution of such violation. Liability under this section shall be joint and several for any violation of this section committed by two or more persons.

(c) Notwithstanding the provisions of subsection (b) of this section concerning treble damages, if the court finds that: (1) A person committing a violation of subsection (a) of this section furnished officials of the state responsible for investigating false claims violations with all information known to such person about the violation not later than thirty days after the date on which the person first obtained the information; (2) such person fully cooperated with an investigation by the state of such violation; and (3) at the time such person furnished the state with the information about the violation, no criminal prosecution, civil action or administrative action had commenced under sections 17b-301c to 17b-301g, inclusive, as amended by this act, with respect to such violation, and such person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than two times the amount of damages which the state sustains because of the act of such person. Any information furnished pursuant to this subsection shall be exempt from disclosure under section 1-210.

Sec. 155. Subsection (d) of section 17b-301d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from*

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passage):

(d) If a person brings an action under this section, [or the federal False Claims Act, 31 USC 3729, et seq.,] no person other than the state may intervene or bring a related action based on the facts underlying the pending action.

Sec. 156. Subsection (f) of section 17b-301e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) Notwithstanding the provisions of subsection (e) of this section, where the action is one that the court finds to be based primarily on disclosures of specific information that was not provided by the person bringing the action relating to allegations or transactions (1) in a criminal, civil or administrative hearing, (2) in a report, hearing, audit or investigation conducted by the General Assembly, a committee of the General Assembly, the Auditors of Public Accounts, a state agency or a quasi-public agency, or (3) from the news media, the court may award from such proceeds to the person bringing the action such sums as it considers appropriate, but in no case more than ten per cent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any such person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees and costs shall be awarded against the defendant.

Sec. 157. Section 17b-301i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No court shall have jurisdiction over an action brought under section 17b-301d, as amended by this act, (1) against a member of the General Assembly, a member of the judiciary or an elected officer or

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department head of the state if the action is based on evidence or information known to the state when the action was brought; or (2) that is based upon allegations or transactions that are the subject of a civil suit or an administrative civil penalty proceeding in which the state is already a party. ; or (3) that is based upon the public disclosure of allegations or transactions (A) in a criminal, civil or administrative hearing, (B) in a report, hearing, audit or investigation, conducted by the General Assembly, a committee of the General Assembly, the Auditors of Public Accounts, a state agency or a quasi-public agency, or (C) from the news media, unless such action is brought by the Attorney General or the person bringing the action is an original source of the information. For the purposes of this subsection, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the state before filing an action under section 17b-301d based on such information.

(b) No court shall have jurisdiction over an action brought under section 17b-301d by a person who knew or had reason to know that the Attorney General or another state law enforcement official knew of the allegations or transactions prior to such person filing the action or serving the disclosure of material evidence.]

(b) Unless opposed by the state, the court shall dismiss an action or claim brought under section 17b-301d, as amended by this act, if allegations or transactions that are substantially the same as those alleged in the action or claim were publicly disclosed (1) in a state criminal, civil or administrative hearing in which the state or its agent is a party, (2) in a report, hearing, audit or investigation conducted by the General Assembly, a committee of the General Assembly, the Auditors of Public Accounts, a state agency or quasi-public agency, or (3) by the news media, except the court shall not dismiss such action or claim if the action or claim is brought by the Attorney General or the

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person who is an original source of information.

(c) For purposes of this section, "original source" means an individual who (1) voluntarily discloses to the state information on which the allegations or transactions in an action or claim are based, prior to public disclosure of such information as described in subdivisions (1), (2) and (3) of subsection (b) of this section, or (2) has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions and has voluntarily provided the information to the state before filing an action or claim under this section.

Sec. 158. Section 17b-301k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any employee, contractor or agent who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment [by his or her employer] because of lawful acts done by the employee [on behalf of the employee or others] , contractor or agent in furtherance of an action under sections 17b-301c to 17b-301g, inclusive, as amended by this act, including investigation for, initiation of, testimony for or assistance in an action filed or to be filed under sections 17b-301c to 17b-301g, inclusive, or efforts to stop a violation of sections 17b-301a to 17b-301p, inclusive, as amended by this act, shall be entitled to all relief necessary to make the employee, contractor or agent whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of any back pay, interest on any back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the Superior Court for the relief provided in this section.

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(b) A civil action or claim under this section may not be brought more than three years after the date on which the retaliation occurred.

Sec. 159. Section 17b-307l of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

A civil action under sections 17b-301c to 17b-301g, inclusive, as amended by this act, may not be brought: (1) More than six years after the date on which the violation of subsection (a) of section 17b-301b, as amended by this act, is committed, or (2) more than three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the state charged with responsibility to act in the circumstances, but in no event more than ten years after the date on which the violation is committed, whichever last occurs. If the state elects to intervene and proceed with an action brought under sections 17b-301c to 17b-301g, inclusive, as amended by this act, the state may file its own complaint or amend the complaint of a person who has brought an action under sections 17b-301c to 17b-301g, inclusive, as amended by this act, to clarify or add detail to claims in which the state is intervening and to add any additional claim under which the state contends that it is entitled to relief. For statute of limitation purposes, any such state pleading shall relate back to the filing date of the complaint of the person who originally brought the action to the extent that the claim of the state arises out of the conduct, transactions or occurrences set forth or attempted to be set forth in the prior complaint of such person.

Sec. 160. Section 154 of public act 11-6 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The Commissioner of Social Services, pursuant to section 17b-10 of the general statutes, may implement policies and procedures necessary to administer the provisions of [this act] section 17b-321 of the general statutes, as amended by section 150 of public act 11-6, and sections 151

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to 153, inclusive, of public act 11-6, while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. [Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.] Such policies and procedures shall remain valid for three years following the date of publication in the Connecticut Law Journal unless otherwise provided for by the General Assembly. Notwithstanding the time frames established in subsection (c) of section 17b-10, the commissioner shall submit such policies and procedures in proposed regulation form to the legislative regulation review committee not later than three years following the date of publication of its intent to adopt regulations as provided for in this subsection. In the event that the commissioner is unable to submit proposed regulations prior to the expiration of the three-year time period as provided for in this subsection, the commissioner shall submit written notice, not later than thirty-five days prior to the date of expiration of such time period, to the legislative regulation review committee and the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies indicating that the department will not be able to submit the proposed regulations on or before such date and shall include in such notice (1) the reasons why the department will not submit the proposed regulations by such date, and (2) the date by which the department will submit the proposed regulations. The legislative regulation review committee may require the department to appear before the committee at a time prescribed by the committee to further explain such reasons and to respond to any questions by the committee about the policy. The legislative regulation review committee may request the joint standing committee of the General Assembly having cognizance of matters relating to human services to review the department's policy, the department's reasons

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for not submitting the proposed regulations by the date specified in this section and the date by which the department will submit the proposed regulations. Said joint standing committee may review the policy, such reasons and such date, may schedule a hearing thereon and may make a recommendation to the legislative regulation review committee.

Sec. 161. Subsection (a) of section 17b-321 of the general statutes, as amended by section 150 of public act 11-6, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) On or before July 1, 2005, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and nursing homes of such amount. The user fee shall be (1) the sum of each nursing home's anticipated nursing home net revenue, including, but not limited to, its estimated net revenue from any increases in Medicaid payments, during the twelve-month period ending on June thirtieth of the succeeding calendar year, (2) which sum shall be multiplied by a percentage as determined by the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Social Services, provided before January 1, 2008, such percentage shall not exceed six per cent, on and after January 1, 2008, and prior to October 1, 2011, such percentage shall not exceed five and one-half per cent, and on and after October 1, 2011, such percentage shall not exceed the maximum allowed under federal law, and (3) which product shall be divided by the sum of each nursing home's anticipated resident days during the twelve-month period ending on June thirtieth of the succeeding calendar year. The Commissioner of Social Services, in anticipating nursing home net revenue and resident days, shall use the most recently available nursing home net revenue and resident day information. Notwithstanding the provisions of this section, the Commissioner of

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Social Services may adjust the user fee as necessary to prevent the state from exceeding the maximum allowed under federal law.

Sec. 162. Section 152 of public act 11-6 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

On or before July 1, 2011, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and the intermediate care facilities for the mentally retarded of such amount. The user fee shall be (1) the sum of each facility's anticipated net revenue, including, but not limited to, its estimated net revenue from any increases in Medicaid payments during the twelve-month period ending on June thirtieth of the succeeding calendar year, (2) which sum shall be multiplied by a percentage as determined by the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Social Services, provided, before October 1, 2011, such percentage shall not exceed five and one-half per cent and, on and after October 1, 2011, such percentage shall not exceed the maximum amount allowed under federal law, and (3) which product shall be divided by the sum of each facility's anticipated resident days during the twelve-month period ending on June thirtieth of the succeeding calendar year. The Commissioner of Social Services, in anticipating facility net revenue and resident days, shall use the most recently available facility net revenue and resident day information. Notwithstanding the provisions of this section, the Commissioner of Social Services may adjust the user fee as necessary to prevent the state from exceeding the maximum amount allowed under federal law.

Sec. 163. (*Effective from passage*) (a) There is established a childhood immunization task force. Said task force shall: (1) Develop a plan to (A) maintain access to high-quality immunizations for children in the state, (B) determine how to respond to recommendations by the National

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Centers for Disease Control and Prevention for new childhood immunizations not currently provided by the state immunization program administered by the Department of Public Health, (C) implement a program permitting health care providers who administer vaccines to children under the federal Vaccines for Children program to select, and the Department of Public Health to provide, vaccines licensed by the federal Food and Drug Administration, and (D) determine how best to cover the cost of immunizations for children in the state, and (2) consider whether the state should continue universal immunization for children in the state.

(b) The task force shall consist of the following members:

(1) Two representatives of the pharmaceutical industry, one each appointed by the speaker of the House of Representatives and the president pro tempore of the Senate;

(2) Two representatives of the insurance industry, one each appointed by the minority leader of the House of Representatives and the minority leader of the Senate;

(3) Two representatives of the American Academy of Pediatrics, one each appointed by the majority leader of the House of Representatives and the majority leader of the Senate;

(4) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(5) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to human services;

(6) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters

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relating to appropriations and the budgets of state agencies;

(7) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to insurance;

(8) The Commissioner of Public Health, or the commissioner's designee;

(9) The Commissioner of Insurance, or the commissioner's designee;

(10) The Commissioner of Social Services, or the commissioner's designee;

(11) The Secretary of the Office of Policy and Management, or the secretary's designee; and

(12) An employee of the Department of Public Health, appointed by the Commissioner of Public Health, responsible for immunizations.

(c) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy of an appointed membership shall be filled by the appointing authority.

(d) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force, from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health and the staff of the Office of Legislative Research shall serve as administrative staff of the task force.

(f) Not later than February 1, 2012, the task force shall submit a

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report on its findings and recommendations, including recommendations for legislation, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, appropriations and the budgets of state agencies and insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or February 1, 2012, whichever is later.

Sec. 164. (NEW) (*Effective July 1, 2012*) (a) Except as provided in subsection (b) of this section, the Commissioner of Children and Families shall not place a child under the age of six, or a sibling group that contains a child under the age of six, in a child care facility, as defined in section 17a-93 of the general statutes.

(b) The Commissioner of Children and Families may place a child under the age of six, or a sibling group containing a child under the age of six, in a child care facility, only if (1) a child care facility is designed for children and their parents, or (2) the health needs of the child under the age of six are so severe that the child's health needs can only be met in a child care facility. No child under the age of six, nor any sibling group containing a child under the age of six, may be placed in a child care facility pursuant to subdivision (2) of this subsection unless the commissioner, not later than ninety-six hours after such placement, certifies to the court that specific attempts were made to secure a family-based placement for such child or sibling group. If a child under the age of six, or sibling group containing a child under the age of six, is placed in a child care facility pursuant to subdivision (2) of this subsection and remains in such facility for more than thirty days, the commissioner shall petition the court for an emergency placement review hearing to be held not less than forty-five days after the date of initial placement. The purpose of such hearing shall be to review the efforts made by the commissioner to secure a family-based placement for the child or sibling group and to determine

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whether continued placement in the child care facility is warranted based on the child's health needs.

Sec. 165. (NEW) (*Effective July 1, 2011*) (a) The Commissioner of Social Services and the Labor Commissioner shall, within available appropriations, implement a pilot program that serves not more than one hundred persons who are receiving benefits under the temporary family assistance program and participating in the jobs first employment services program. The pilot program shall provide to participants: (1) Intensive case management services to identify participants' (A) employment goals, (B) support service needs, and (C) training, education and work experience needs; (2) assistance in accessing needed support services, training, education and work experience; and (3) funding to facilitate participation in necessary adult basic education, skills training, postsecondary education or subsidized employment.

(b) Notwithstanding the provisions of subsections (a) and (c) of section 17b-112 of the general statutes, the Commissioner of Social Services shall grant extensions of time-limited cash assistance benefits to any person who (1) has made a good-faith effort to comply with the requirements of the pilot program, (2) has not exceeded the sixty-month limit, described in subsection (c) of section 17b-112 of the general statutes, and (3) has not been granted more than two extensions.

(c) Not later than October 1, 2012, the Commissioner of Social Services and the Labor Commissioner shall jointly submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies concerning the pilot program. Such report shall include, but shall not be limited to: (1) The number of persons participating in the pilot program; (2) the education, training

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and work experience activities of the participants; (3) the support services identified as needed by program participants through the provision of case management services by the Department of Social Services and the Labor Department and the support services actually received by each program participant; (4) the educational degrees and certificates obtained by participants; and (5) descriptions of the employment obtained by participants as a result of the pilot program.

Sec. 166. Section 17b-343 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The Commissioner of Social Services shall establish annually the maximum allowable rate to be paid by [said] agencies for homemaker services, chore person services, companion services, respite care, meals on wheels, adult day care services, case management and assessment services, transportation, mental health counseling and elderly foster care, except that the maximum allowable rates in effect July 1, 1990, shall remain in effect during the fiscal years ending June 30, 1992, and June 30, 1993. The Commissioner of Social Services shall prescribe uniform forms on which agencies providing such services shall report their costs for such services. Such rates shall be determined on the basis of a reasonable payment for necessary services rendered. The maximum allowable rates established by the Commissioner of Social Services for the Connecticut home-care program for the elderly established under section 17b-342, as amended by this act, shall constitute the rates required under this section until revised in accordance with this section. The Commissioner of Social Services shall establish a fee schedule, to be effective on and after July 1, 1994, for homemaker services, chore person services, companion services, respite care, meals on wheels, adult day care services, case management and assessment services, transportation, mental health counseling and elderly foster care. The commissioner may annually increase any fee in the fee schedule based on an increase in the cost of

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services. The commissioner shall increase the fee schedule effective July 1, 2000, by not less than five per cent, for adult day care services. The commissioner shall increase the fee schedule effective July 1, 2011, by four dollars per person, per day for adult day care services. Nothing contained in this section shall authorize a payment by the state to any agency for such services in excess of the amount charged by such agency for such services to the general public.

Sec. 167. Section 17b-28 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) There is established a [Council on Medicaid Care Management Oversight] Council on Medical Assistance Program Oversight which shall advise the Commissioner of Social Services on the planning and implementation of [a system of Medicaid care management and] the health care delivery system for the following health care programs: The HUSKY Plan, Parts A and B, the Charter Oak Health Plan and the Medicaid program, including, but not limited to, the portions of the program serving low income adults, the aged, blind and disabled individuals, individuals who are dually eligible for Medicaid and Medicare and individuals with preexisting medical conditions. The council shall monitor [such] planning and implementation [on] of matters related to Medicaid care management initiatives including, but not limited to, (1) eligibility standards, (2) benefits, (3) access, [and] (4) quality assurance, (5) outcome measures, and (6) the issuance of any request for proposal by the Department of Social Services for utilization of an administrative services organization in connection with such initiatives.

(b) [The] On or before June 30, 2011, the council shall be composed of the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies, or their designees; two members of the

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General Assembly, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; the director of the Commission on Aging, or a designee; the director of the Commission on Children, or a designee; a representative of each organization that has been selected by the state to provide managed care and a representative of a primary care case management provider, to be appointed by the president pro tempore of the Senate; two representatives of the insurance industry, to be appointed by the speaker of the House of Representatives; two advocates for persons receiving Medicaid, one to be appointed by the majority leader of the Senate and one to be appointed by the minority leader of the Senate; one advocate for persons with substance use disorders, to be appointed by the majority leader of the House of Representatives; one advocate for persons with psychiatric disabilities, to be appointed by the minority leader of the House of Representatives; two advocates for the Department of Children and Families foster families, one to be appointed by the president pro tempore of the Senate and one to be appointed by the speaker of the House of Representatives; two members of the public who are currently recipients of Medicaid, one to be appointed by the majority leader of the House of Representatives and one to be appointed by the minority leader of the House of Representatives; two representatives of the Department of Social Services, to be appointed by the Commissioner of Social Services; two representatives of the Department of Public Health, to be appointed by the Commissioner of Public Health; two representatives of the Department of Mental Health and Addiction Services, to be appointed by the Commissioner of Mental Health and Addiction Services; two representatives of the Department of Children and Families, to be appointed by the Commissioner of Children and Families; two representatives of the Office of Policy and Management, to be appointed by the Secretary of the Office of Policy and Management; and one representative of the office of the State Comptroller, to be appointed by the State

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Comptroller.

(c) On and after July 1, 2011, the council shall be composed of the following members:

(1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies, or their designees;

(2) Four appointed by the speaker of the House of Representatives, one of whom shall be a member of the General Assembly, one of whom shall be a community provider of adult Medicaid health services, one of whom shall be a recipient of Medicaid benefits for the aged, blind and disabled or an advocate for such a recipient and one of whom shall be a representative of the state's federally qualified health clinics;

(3) Four appointed by the president pro tempore of the Senate, one of whom shall be a member of the General Assembly, one of whom shall be a representative of the home health care industry, one of whom shall be a primary care medical home provider and one of whom shall be an advocate for Department of Children and Families foster families;

(4) Two appointed by the majority leader of the House of Representatives, one of whom shall be an advocate for persons with substance abuse disabilities and one of whom shall be a Medicaid dental provider;

(5) Two appointed by the majority leader of the Senate, one of whom shall be a representative of school-based health centers and one of whom shall be a recipient of benefits under the HUSKY program;

(6) Two appointed by the minority leader of the House of

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Representatives, one of whom shall be an advocate for persons with disabilities and one of whom shall be a dually eligible Medicaid-Medicare beneficiary or an advocate for such a beneficiary;

(7) Two appointed by the minority leader of the Senate, one of whom shall be a low-income adult recipient of Medicaid benefits or an advocate for such a recipient and one of whom shall be a representative of hospitals;

(8) The executive director of the Commission on Aging, or the executive director's designee;

(9) The executive director of the Commission on Children, or the executive director's designee;

(10) A representative of the Long-Term Care Advisory Council;

(11) The Commissioners of Social Services, Children and Families, Public Health, Developmental Services and Mental Health and Addiction Services, or their designees, who shall be ex-officio nonvoting members;

(12) The Comptroller, or the Comptroller's designee, who shall be an ex-officio nonvoting member;

(13) The Secretary of the Office of Policy and Management, or the secretary's designee who shall be an ex-officio nonvoting member; and

(14) One representative of an administrative services organization which contracts with the Department of Social Services in the administration of the Medicaid program, who shall be a nonvoting member.

(d) The council shall choose a [chair] chairperson from among its members. The Joint Committee on Legislative Management shall provide administrative support to such chair. [The council shall

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convene its first meeting no later than June 1, 1994.]

[(b)] (e) The council shall monitor and make recommendations concerning: (1) [guaranteed access to enrollees] An enrollment process that ensures access for each Department of Social Services administered health care program and effective outreach and client education for such programs; (2) available services comparable to those already in the Medicaid state plan, including those guaranteed under the federal Early and Periodic Screening, Diagnostic and Treatment Services Program under 42 USC 1396d; (3) the sufficiency of accessible adult and child primary care providers, specialty providers and hospitals in Medicaid provider networks; (4) the sufficiency of [capitated rates provider payments, financing and staff resources to] provider rates to maintain the Medicaid network of providers and service access; (5) funding and agency personnel resources to guarantee timely access to services and effective management of the Medicaid program; [(5)] (6) participation in care management programs including, but not limited to, medical home and health home models by existing community Medicaid providers; [(6)] (7) the linguistic and cultural competency of providers and other program facilitators [; (7) quality assurance] and data on the provision of Medicaid linguistic translation services; (8) program quality, including outcome measures and continuous quality improvement initiatives that may include provider quality performance incentives and performance targets for administrative services organizations; [(8)] (9) timely, accessible and effective client grievance procedures; [(9)] (10) coordination of the Medicaid care management programs with state and federal health care reforms; [(10)] (11) eligibility levels for inclusion in the programs; [(11)] (12) enrollee cost-sharing provisions; [(12)] (13) a benefit package for each of the health care programs set forth in subsection (a) of this section; [(13)] (14) coordination of coverage [under the HUSKY Plan, Part A, HUSKY Plan, Part B and other health care programs] continuity among Medicaid programs and

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integration of care, including, but not limited to, behavioral health, dental and pharmacy care provided through programs administered by the Department of Social Services; [(14)] and (15) the need for program quality studies within the areas identified in this section and the department's application for available grant funds for such studies. [; (15) the HUSKY Plan, Part A, the HUSKY Plan, Part B, HUSKY Primary Care, the state-administered general assistance program, the Medicaid care management programs and the Charter Oak Health Plan; (16) other issues pertaining to the development of a Medicaid Research and Demonstration Waiver under Section 1115 of the Social Security Act; and (17) the primary care case management pilot program, established pursuant to section 17b-307]. The chairperson of the council shall ensure that sufficient members of the council participate in the review of any contract entered into by the Department of Social Services and an administrative services organization.

[(c)] (f) The Commissioner of Social Services may, in consultation with an educational institution, apply for any available funding, including federal funding, to support Medicaid care management programs.

[(d)] (g) The Commissioner of Social Services shall provide monthly reports to the council on [the plans and implementation of the Medicaid care management program to the council] the matters described in subsection (e) of this section, including, but not limited to, policy changes and proposed regulations that affect Medicaid health services. The commissioner shall also provide the council with quarterly financial reports for each covered Medicaid population which reports shall include a breakdown of sums expended for each covered population.

[(e)] (h) The council shall biannually report on its activities and progress [once each quarter] to the General Assembly.

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Sec. 168. Subdivision (6) of subsection (b) of section 17a-22j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(6) Two appointed by the minority leader of the Senate one of whom is a provider of community-based services for children with behavioral health problems and one of whom is a member of the [advisory council on Medicaid care management oversight] Council on Medical Assistance Program Oversight;

Sec. 169. Subsection (c) of section 17b-28e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) Each care management organization that enters into a contract with the Department of Social Services to provide foreign language interpreter services under the HUSKY Plan, Part A shall report, semi-annually, to the department on the interpreter services provided to recipients of benefits under the program. Such written reports shall be submitted to the department not later than June first and December thirty-first each year. Not later than thirty days after receipt of such report, the department shall submit a copy of the report, in accordance with the provisions of section 11-4a, to the [Council on Medicaid Care Management Oversight] Council on Medical Assistance Program Oversight.

Sec. 170. Subsection (c) of section 17b-261i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The commissioner shall submit a report to the [Council on Medicaid Care Management Oversight] Council on Medical Assistance Program Oversight, not later than thirty days after making any policy change pursuant to this section.

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Sec. 171. Subsection (a) of section 17b-297 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The commissioner, in consultation with the Children's Health Council, the [Council on Medicaid Care Management Oversight] Council on Medical Assistance Program Oversight and the 2-1-1 Infoline program, shall develop mechanisms to increase outreach and maximize enrollment of eligible children and adults in the HUSKY Plan, Part A or Part B, including, but not limited to, development of mail-in applications and appropriate outreach materials through the Department of Revenue Services, the Labor Department, the Department of Social Services, the Department of Public Health, the Department of Children and Families and the Office of Protection and Advocacy for Persons with Disabilities. Such mechanisms shall seek to maximize federal funds where appropriate for such outreach activities.

Sec. 172. Section 17b-306a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The Commissioner of Social Services, in collaboration with the Commissioners of Public Health and Children and Families, shall establish a child health quality improvement program for the purpose of promoting the implementation of evidence-based strategies by providers participating in the HUSKY Plan, Part A and Part B to improve the delivery of and access to children's health services. Such strategies shall focus on physical, dental and mental health services and shall include, but need not be limited to: (1) Methods for early identification of children with special health care needs; (2) integration of care coordination and care planning into children's health services; (3) implementation of standardized data collection to measure performance improvement; and (4) implementation of family-centered services in patient care, including, but not limited to, the development of parent-provider partnerships. The Commissioner of Social Services

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shall seek the participation of public and private entities that are dedicated to improving the delivery of health services, including medical, dental and mental health providers, academic professionals with experience in health services research and performance measurement and improvement, and any other entity deemed appropriate by the Commissioner of Social Services, to promote such strategies. The commissioner shall ensure that such strategies reflect new developments and best practices in the field of children's health services. As used in this section, "evidence-based strategies" means policies, procedures and tools that are informed by research and supported by empirical evidence, including, but not limited to, research developed by organizations such as the American Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners and the Institute of Medicine.

(b) Not later than July 1, 2008, and annually thereafter, the Commissioner of Social Services shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations, and to the [Council on Medicaid Care Management Oversight] Council on Medical Assistance Program Oversight on (1) the implementation of any strategies developed pursuant to subsection (a) of this section, and (2) the efficacy of such strategies in improving the delivery of and access to health services for children enrolled in the HUSKY Plan.

(c) The Commissioner of Social Services, in collaboration with the [Council on Medicaid Care Management Oversight] Council on Medical Assistance Program Oversight, shall, subject to available appropriations, prepare, annually, a report concerning health care choices under the HUSKY Plan, Part A. Such report shall include, but not be limited to, a comparison of the performance of each managed

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care organization, the primary care case management program and other member service delivery choices. The commissioner shall provide a copy of each report to all HUSKY Plan, Part A members.

Sec. 173. (NEW) (*Effective July 1, 2011*) The Commissioner of Public Health shall establish and contract for the administration of a program using AIDS Services funding to provide financial assistance to victims of sexual assault for drugs prescribed by a physician for nonoccupational post-exposure prophylaxis for human immunodeficiency virus consistent with recommendations of the National Centers for Disease Control and Prevention and the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault. The commissioner shall give priority for benefits under the program established pursuant to this section to sexual assault victims who are uninsured or underinsured and for whom the program is a payer of last resort. The commissioner shall issue a request for proposal totaling twenty-five thousand dollars annually to which a qualified organization may apply to administer the program.

Sec. 174. Subsection (a) of section 19a-649 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) The office [, in consultation with the Commissioner of Social Services,] shall review annually the level of uncompensated care provided by each hospital to the indigent. Each hospital shall file annually with the office its policies regarding the provision of charity care and reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices. [Each hospital shall obtain an independent audit of the level of charges, payments and discharges by primary payer related to Medicare, medical assistance, CHAMPUS or TriCare and nongovernmental payers as well as the amount of uncompensated care including emergency assistance to families. The results of this audit, including the above information,

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with an opinion, shall be provided to the office by each hospital by March thirty-first of each year, and the hospital's audited financial statements shall be provided by February twenty-eighth of each year. For purposes of this section, "primary payer" means the payer responsible for the highest percentage of charges for a patient's inpatient or outpatient hospital services. The office shall evaluate the audit and may rely on the information contained in the independent audit or may require such additional audit as it deems necessary.] A hospital shall file its audited financial statements by February twenty-eighth of each year. The filing shall include a verification of the hospital's net revenue for the most recently completed fiscal year in a format prescribed by the office.

Sec. 175. Section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

As used in this [section and sections 19a-662, 19a-669 to 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672 and 19a-676] this chapter, unless the context otherwise requires:

(1) "Office" means the Office of Health Care Access division of the Department of Public Health;

(2) "Hospital" means any hospital licensed as a short-term acute care general or children's hospital by the Department of Public Health, including John Dempsey Hospital of The University of Connecticut Health Center;

(3) "Fiscal year" means the hospital fiscal year consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

[(4) "Base year" means the fiscal year consisting of a twelve-month period immediately prior to the start of the fiscal year for which a budget is being determined or prepared;]

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[(5)] (4) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization;

[(6)] (5) "Uncompensated care" means the total amount of charity care and bad debts determined by using the hospital's published charges and consistent with the hospital's policies regarding charity care and bad debts which [have been approved by, and] are on file at [.] the office;

[(7)] (6) "Medical assistance" means (A) the programs for medical assistance provided under [the state-administered general assistance program or] the Medicaid program, including the HUSKY Plan, Part A, or (B) any other state-funded medical assistance program, including the HUSKY Plan, Part B;

[(8)] (7) "CHAMPUS" or "TriCare" means the federal Civilian Health and Medical Program of the Uniformed Services, as defined in 10 USC [Section] 1072(4), as from time to time amended;

[(9)] (8) "Primary payer" means the payer responsible for the highest percentage of the charges for a patient's inpatient or outpatient hospital services;

[(10)] (9) "Case mix index" means the arithmetic mean of the Medicare diagnosis related group case weights assigned to each inpatient discharge for a specific hospital during a given fiscal year. The case mix index shall be calculated by dividing the hospital's total case mix adjusted discharges by the hospital's actual number of discharges for the fiscal year. The total case mix adjusted discharges shall be calculated by (A) multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for that same diagnosis-related group and fiscal year, and (B) then totaling the resulting products for all diagnosis-related groups;

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[(11)] (10) "Contractual allowances" means the difference between hospital published charges and payments generated by negotiated agreements for a different or discounted rate or method of payment;

[(12)] (11) "Medical assistance underpayment" means the amount calculated by dividing the total net revenue by the total gross revenue, and then multiplying the quotient by the total medical assistance charges, and then subtracting medical assistance payments from the product;

[(13)] (12) "Other allowances" means the amount of any difference between charges for employee self-insurance and related expenses determined using the hospital's overall relationship of costs to charges;

[(14)] (13) "Gross revenue" means the total gross patient charges for all patient services provided by a hospital; and

[(15)] (14) "Net revenue" means total gross revenue less contractual allowance, less the difference between government charges and government payments, less uncompensated care and other allowances. [, plus uncompensated care program disproportionate share hospital payments from the Department of Social Services;

(16) "Emergency assistance to families" means assistance to families with children under the age of twenty-one who do not have the resources to independently provide the assistance needed to avoid the destitution of the child.]

Sec. 176. Section 19a-670 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

[(a)] Within available appropriations, the Department of Social Services may make semimonthly payments to short-term general hospitals in an amount calculated pursuant to section 19a-671, provided the total amount of payments made to individual hospitals

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and to hospitals in the aggregate shall maximize the amount qualifying for federal matching payments under the medical assistance program as determined by the Department of Social Services in consultation with the Office of Policy and Management. No payments shall be made to any hospital exempt from taxation under chapter 211a. The payments shall be medical assistance disproportionate share payments, including grants provided pursuant to section 19a-168k, to the extent allowable under federal law. The payments shall not be part of the routine medical assistance inpatient hospital rate determined pursuant to section 17b-239. Payments shall be made on an interim basis during each year and a final settlement shall be calculated pursuant to section 19a-671 by the office for each hospital after the year end based on audited data for the hospitals. The Commissioner of Social Services may withhold payment to a hospital which is in arrears in remitting its obligations to the state.

(b) (1) For the hospital fiscal year 1994, and subsequent fiscal years, the commission or its designated representative shall conduct a cash audit of the projected amount of uncompensated care, including emergency assistance to families and underpayments against the actual receipts of the hospital. In addition, the office or its designated intermediary shall conduct an audit of the revenues, deductions from revenue, discharges, days or other measures of patient volume for hospitals for the purposes of termination and final settlement of uncompensated care pool assessments and payments for the period ending March 31, 1994.

(2) For the six-month period ending September 30, 1994, and for each subsequent fiscal year, the office or its designated intermediary shall conduct an audit of the revenues, deductions from revenue, discharges, days or other measures of patient volume for hospitals for the purposes of determining disproportionate share payments. Included in this audit shall be a comparison of projected and actual

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levels of medical assistance underpayment and uncompensated care.

(3) The total payments from the Department of Social Services medical assistance disproportionate share-emergency assistance account established pursuant to section 38 of public act 94-9* and made in accordance with sections 19a-670 to 19a-672, inclusive, during the fiscal year less any payments for emergency assistance to families, and less any payments resulting from the resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, shall be reallocated to hospitals based on actual audited levels of medical assistance underpayment, grants pursuant to section 19a-168k and uncompensated care to determine the final payment for the fiscal year.

(4) If the final payment for a hospital for the hospital fiscal year, as determined as a result of this audit, is less than the total payments the hospital received during the same fiscal year excluding any prior year audit adjustment, then the current hospital fiscal year remaining semimonthly payments shall each be reduced by an amount equal to the total excess payment divided by the number of remaining semimonthly payments for the current hospital fiscal year.

(5) If the final payment for a hospital for the hospital fiscal year, as determined as a result of this audit, is greater than the total payments the hospital received during the same fiscal year, then the current hospital fiscal year remaining semimonthly payments shall each be increased by an amount equal to the total excess payment divided by the number of remaining semimonthly payments for the current hospital fiscal year.]

[(6)] The office shall, by [June 1, 1995, and June first of each subsequent] September first of each year, report the results of [such audit] the office's review of the hospitals' annual and twelve-month filings under sections 19a-644, 19a-649 and 19a-676 for the previous

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hospital fiscal year to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The report shall include information concerning the financial stability of hospitals in a competitive market.

[(7) Notwithstanding the provisions of subdivisions (3) to (5), inclusive, of this subsection, no adjustment of disproportionate share payments to hospitals for purposes of final settlement shall be implemented for the hospital fiscal years commencing October 1, 1997, and October 1, 1998, provided every hospital subject to final settlement for said fiscal years submits documentation in writing of its agreement to forego such final settlement to the Commissioner of Social Services in a form acceptable to the commissioner.

(8) Notwithstanding the provisions of subdivisions (3) to (5), inclusive, of this subsection, for the hospital fiscal year commencing October 1, 1999, and for each subsequent fiscal year, no adjustment of disproportionate share payments to hospitals for purposes of final settlement shall be determined or implemented.

(9) For the quarter ending September 30, 2001, no negative adjustment to the disproportionate share payments to hospitals for purposes of implementing the final one-quarter of the disproportionate share final settlement for the hospital fiscal year commencing October 1, 1998, shall be made. Any hospitals with a positive adjustment to the disproportionate share payments for purposes of implementing the remaining one-quarter of the hospital fiscal year 1999 disproportionate share final settlement shall receive payment of the adjustment through funds appropriated for said purpose.

(10) The Department of Social Services may, within available appropriations and with the approval of the Office of Health Care Access and the Office of Policy and Management, make payment of

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any final settlement amount determined to represent any and all claims arising out of any incorrect payments to Yale-New Haven Hospital for the fiscal quarter ending September 30, 1998, or the hospital fiscal year ending September 30, 1999, or both. If such incorrect payment, whether an overpayment or an underpayment, has occurred as a result of the hospital's reporting incorrect information and statistics to the Office of Health Care Access, the Office of Health Care Access shall recompute the amount of any payments for the indicated time periods, offsetting any underpaid amount by the amount of any overpayment of funds for the indicated time period. Yale-New Haven Hospital shall submit all information and documentation determined necessary by the Office of Health Care Access to make a final determination of the amounts due. Prior to the release of any funds under this section, the hospital shall submit a written release in a form satisfactory to the Secretary of the Office of Policy and Management. The written release shall provide for settlement of any and all claims which have been or could have been brought challenging the amount of payment for the indicated periods. Nothing in this section shall be construed to relieve the hospital from any settlement or adjustments for any periods other than those identified in this section.

(c) The Commissioner of Social Services is authorized to determine exceptions, exemptions and adjustments in accordance with 42 CFR 413.40.

(d) Nothing in section 3-114i, subdivision (2) or (29) of subsection (a) of section 12-407, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision (1) of section 12-414, or sections 12-263a to 12-263e, inclusive, section 19a-646, 19a-659, 19a-662 or 19a-669 to 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and section 19a-676, or section 1, 2, or 38 of public act 94-9* shall be construed to require the Department of Social Services to pay

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out more funds than are appropriated pursuant to said sections.]

Sec. 177. Subsection (c) of section 19a-493b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) Notwithstanding the provisions of this section, no outpatient surgical facility shall be required to comply with section 19a-631, 19a-632, 19a-644, 19a-645, 19a-646, 19a-649, 19a-654 to 19a-660, inclusive, as amended by this act, [19a-662,] 19a-664 to 19a-666, inclusive, [19a-669 to 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672] 19a-673 to 19a-676, inclusive, as amended by this act, 19a-678, [or] 19a-681, [to] or 19a-683. [, inclusive.] Each outpatient surgical facility shall continue to be subject to the obligations and requirements applicable to such facility, including, but not limited to, any applicable provision of this chapter and those provisions of chapter 368z not specified in this subsection, except that a request for permission to undertake a transfer or change of ownership or control shall not be required pursuant to subsection (a) of section 19a-638 if the Office of Health Care Access division of the Department of Public Health determines that the following conditions are satisfied: (1) Prior to any such transfer or change of ownership or control, the outpatient surgical facility shall be owned and controlled exclusively by persons licensed pursuant to section 20-13, either directly or through a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13, or is under the interim control of an estate executor or conservator pending transfer of an ownership interest or control to a person licensed under section 20-13, and (2) after any such transfer or change of ownership or control, persons licensed pursuant to section 20-13, a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited

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liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13, shall own and control no less than a sixty per cent interest in the outpatient surgical facility.

Sec. 178. Sections 10-294, 17a-453a, 17a-453b, 17b-192, 17b-200, 17b-240, 17b-256d, 17b-261k, 17b-263b, 17b-265e, 17b-371, 17b-424, 17b-492a, 17b-651, 17b-652, 17b-664, 19a-662, 19a-669, 19a-670a, 19a-671, 19a-671a, 19a-672, 19a-672a and 19a-683 of the general statutes are repealed. (*Effective July 1, 2011*)

Approved June 13, 2011